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ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY  
ARISING FROM THE USE OF ASBESTOS IN ONTARIO

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Mr. N. McCombie	Injured Workers Consultants

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180 Dundas Street  
Toronto, Ontario  
Tuesday,  
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VOLUME 39

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ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY  
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VOLUME 39

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THE FURTHER PROCEEDINGS IN THIS INQUIRY  
RESUMED PURSUANT TO ADJOURNMENT

APPEARANCES AS HERETOFORE NOTED

DR. DUPRE: Good morning, ladies and gentlemen.  
We shall convene.


Counsel, are there any matters before I greet the  
witness?

MR. LASKIN: Just that there's one new face at  
the counsel table, Mr. Chairman, who is Susan Valentine, who is  
associated with David Starkman, in his office.

DR. DUPRE: Ms. Valentine, welcome.

MR. LASKIN: The only other matter is, Mr.  
Commissioner, I won't take the time now, but perhaps I could just  
ask all of the counsel behind me, and Tom Lederer, if we could  
just have a little meeting after this hearing, for about ten  
minutes, so we can discuss future hearing dates and future  
witnesses. I won't take the time of the Commission now.

DR. DUPRE: Well, may I welcome, please, Dr.  
Jerry Vingilis, M.D., some time of the Occupational Health Branch,  
fresh this morning from the operating room. You are welcome,



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Vingilis, in-ch

DR. DUPRE: Dr. Vingilis. May I ask you, please, to step forward so that you may be sworn in?

5 DR. JEROME JOSEPH VINGILIS, SWORN

EXAMINATION-IN-CHIEF BY MR. LASKIN

Q. Dr. Vingilis, you are a medical doctor?

A. Yes.

10 Q. Can you tell us very briefly what your educational background is, and your professional qualifications?

A. I graduate from medicine in 1943, in Italy. I specialized in chest diseases from 1943 until 1948. In 1948, arrived in Canada.

15 I did my junior internship in 1950. I passed my Canadian Council exams in 1942, and I joined the Ministry of Health Occupational Chest Disease Service on February 23, 1953, as a clinician.

Q. As I understand it, you remained employed by the Ontario Government from that time forward until very recently this year?

20 A. Until February 28, 1982.

Q. Can you just outline for us very briefly what positions you held in the Ontario Government, and what your functions were in those positions?

25 A. I was hired as a clinician in the Occupational Chest Disease Service, and workers exposed to silica, asbestos, talc and other injurious dusts to the lungs. Our job was to do mass screening, reading the films, interpretation, contacting the people who were suffering, or suspected of suffering occupational disease, and then referring them to family physician and to Workmen's Compensation Board, if it's relevant, for their consideration.

30 Q. How long did you remain a clinician in the



Q. (cont'd.) Ministry of Health?

A. I think 1970. I was in charge of all Occupational Chest Disease clinics, and in 1974 became Chief of Occupational Chest Disease Service.

Q. At that time was that operated out of the Ministry of Labour or the Ministry of Health?

A. Ministry of Health. Transferred to Ministry of Labour just recently, I think the past two years.

Q. Following the passage of the Occupational Health and Safety Act?

A. About, yes.

Q. Then I take it from your evidence that in the mid-1970's you became head of the Occupational Chest Disease Service?

A. Yes.

Q. And that included operating the mobile x-ray units?

A. Yes, and laboratory and...well, x-ray units, stationary units in the clinic, and lung function laboratory.

Q. And since February of 1982, you have been in private practice?

A. Yes.

Q. Am I also correct that throughout the period of time you were in the Ontario Government you were also a member of the Workmen's Compensation Board advisory committee on occupational chest disease?

A. Yes. That's since I was appointed physician in charge of occupational chest disease, and when a vacancy became available I was invited to join them.

Q. What date, approximately?

A. It would be around 1970, 1971.

Q. And you remained a member of the committee





Q. (cont'd.) until you left the government?

A. I'm still a member of the committee.

Q. You are still a member of the committee? Even though you are in private practice?

A. Even in private practice.

The committee is built of independent physicians practicing in different parts of...there is a mixed group of physicians. It's not the government physicians.

Q. Okay. I want to ask you...I'm going to come back and ask you some questions about that advisory committee, but can I first ask you some questions about your role with the Occupational Chest Disease Service, and can you tell us briefly when that service started and what it involved?

A. Well, historically, I think the service started during the Second World War, or I think maybe a little earlier. I think the service started very early - something about 1927, 1928, went into the mines and so on. But, well, I just learned from the other doctors, I would not like this to be quoted or registered. I just can tell from 1973, February, then I remember exactly.

But in February, 1972, was passed the Silicosis Act and Regulations, and then all service industries under the law had to be examined by us. Then I was hired in this position.

Unfortunately, asbestos was not considered for regulations, and asbestos service was strictly on voluntary basis.

Q. So that, if I understand your evidence, insofar as the service was applied to operations that involved silica, it was mandatory for the employee to avail himself of the service.

A. Yes.

Q. In respect of asbestos operations, it was voluntary?



A. Voluntary, yes.

Q. Was the service being applied to asbestos operations when you joined the government?

A. Yes. At that time we introduced, we tried to persuade the companies, and in the majority of cases we have been successful.

Q. All right. Did you utilize your services at, for example, Johns-Manville, when you first joined the company?

A. Yes. I think initially Johns-Manville was x-rayed a little earlier, before I joined. But the main service starts about 1970, 1971, 1972.

When I joined in 1972, the service was in full swing.

Q. 1972 or 1952?

A. I'm sorry. 1952.

Q. So that when you joined the government in 1952, the service was...

A. Already in process.

Q. All right.

A. Just very new, but it was in process.

Q. All right. Can you tell me what the service involved, first of all how often were employees examined...and let's take Johns-Manville to use as an example, the Scarborough plant?

A. Well, at this time we surveyed about sixty thousand employees in Ontario, and at that time for silica and for other industries been used miniature films, seven millimeter films.

Since I knew about asbestos still in vague way, because asbestos at that time was not that much researched, I suggested strongly that we start large fourteen by seventeen films, and we introduced from very beginning normal large chest





5 A. (cont'd.) x-ray film for all asbestos workers, and at that time we used to survey plants every eighteen months. We made exception for Johns-Manville to do every twelve months.

Q. What was the reason for that?

A. Because there was a new product, there was some rumors that it was potentially dangerous, there was some rumors it was potentially carcinogenic, and we took this very seriously.

10 Q. Was there any particular reason why you differentiated in the frequency of your examinations at Johns-Manville as opposed to other asbestos operations?

15 A. I think the subtle reason was this one - because at that time we expected a double exposure. There used to be some silica exposure, and there was some asbestos exposure, and we knew that changes on the x-ray in asbestos are far more subtle than in silica, so not to overlook or not to miss the cases, we introduced yearly, first reason.

20 Second reason, there was some kind of study purpose, too. We want to take seriously and study and follow, and maybe later date publish our results.

Q. In terms of the frequency of examination, did you differentiate between short- and long-term employees?

25 A. At that time it just meant...they all been new employees because the plant was just opened, and to my knowledge not many people been exposed elsewhere to asbestos.

So in 1952, 1953, all employees...the majority of employees, I would say...been new employees.

Q. So you examined them yearly?

A. Yearly, yes.

Q. Did that pattern change everytime?

30 A. No, we didn't change pattern. We just kept going. Oh, a little change later on, I think about 1970's when the cancer cases appeared more frequently, the senior employees...



5 A. (cont'd.) ...with the agreement of the union... we x-rayed every six months. Employees who had been twenty years or more exposed to asbestos, we tried to x-ray every six months because, as you are aware, the cancer is not as easily detected, particularly in the harder areas, and one year intervals, for us, looked maybe too long - it would be nicer to detect earlier, is possible surgical susceptibility more feasible.

10 Q. Did you examine employees only in the transite pipe section of Johns-Manville, or did you examine other employees?

A. I have the impression that we examined all employees, and a good number, even, office staff.

But I think the plant staff maybe could confirm or deny.

15 Q. Was the program purely voluntary on the part of the Johns-Manville employees?

A. From the government's point of view, yes, because there was no...but I have to admit we had good co-operation.

Q. From whom?

20 A. From the employees.

Q. Do you have any approximate percentage of how many employees at Johns-Manville, over time, took advantage of the program and were you getting nearly a hundred percent turnout, or less than that?

25 A. Well, when we arrive in the plant there is always certain numbers missing for different reasons - absent, vacation, so on. But either plant tried to sometimes send them later on to our office, or...well, they used to pick up next year.

I think was good co-operation. Percentage-wise, I could not tell exactly. If you say eighty percent, it would be very close.

30 Q. What did the examination involve? Was it





Q. (cont'd.) simply taking x-rays?

A. Yeah. In the beginning was just simply taking the x-rays.

Q. Were there any lung function tests done?

A. Lung function test was introduced later, when the lung function by itself, as a science, developed further and get some credibility of the value, we introduced lung function studies, too.

Q. Do you know when that was, approximately?

A. Would be something around 1970, I presume. Well, this I quoting strictly by memory, and one or two years any direction could be correct.

Q. Who read the x-rays, Dr. Vingilis?

A. Well, x-ray, our staff. I personally was involved in the majority of reading.

Q. You personally?

A. Yes.

Q. Were the x-rays of the employees read by you alone, or were they read by more than one reader?

A. Just now, we never read...well, there is always consultation with other doctors if you see something unusual, but the majority, yes, I read myself.

Q. We've heard from time to time some evidence before this Commission about the difficulties, perhaps, in reading x-rays, and the problems of having...not having more than one reader. I'm just wondering, was there from time to time any check by your department as to whether the x-rays were being read accurately, or being read in accordance with standards applied elsewhere?

A. Well, I heard this rumor. I was very pleased to contact two other groups that have been more experienced in asbestos reading - one was the Selikoff group in New York, and another group in Boston - and we sent three hundred random



A. (cont'd.) films to reread, to them, and they did reread and I was very glad to find, to hear that there was absolutely unanimous agreement with our interpretation.

Q. When did you do that?

A. 1973, 1974.

Q. What prompted you to do that?

A. Just the plain, the rumor, because we heard that there was a little dissatisfaction, that maybe Toronto doctors do not know how to interpret asbestosis.

Q. What...

A. Next thing, at that time I informed the employees and plants that anyone who is in doubt about our interpretation, I volunteer to give them films and take them to any radiologist in Toronto, or anywhere, to doublecheck, and we used to spread the films very freely to any radiologist. There was no secret, and we were glad to show them.

The same Dr. Sanders who is chief chest radiologist in the University of Toronto, we sent to him quite a number of films to double read.

Q. Tell us what you did with the results of examinations?

A. I think during this thirty years there was a pattern, a little changing. In beginning, we reported only the positive results to the plant doctor.

Q. That's the company doctor?

A. To the company doctor.

Q. And who was...

A. Now I have to put positive...we classified the results in three categories of intensity or severity. If I see the man has like pneumonia, he has the pleurisy, he has suspected cancer, well this report was referred right away to the man's family physician. If we do not know the man's family



5 A. (cont'd.) physician, we try to contact him or his wife and get it right away. This was done, everything, by telephone, and his family physician was informed and this report was informed by telephone, later on by mail, and film was referred to him for further followup.

Now, next severity is minor changes, or so-called irrelevant changes - like pleural adhesions, scars, calcifications. Those been reported only, in the beginning, to the plant physician.

10 Later on, we changed and in about 1972 or 1973, we been asked to send all reports to the family physician. So with the help of the plant medical staff, we been able to secure the family physician's names, and we mailed all reports to the family physician, whether positive or negative.

15 Q. Let me just see if I can understand that and go over that.

Throughout the thirty year period, the company doctor - whoever it may have been, I take it - received the results of the examinations, whether they be positive, negative, or...

20 A. In the beginning, I think only the positives. Because was sixty thousand reports to mail, all negative, that was far too big, too large a number, and just physically we have no resources, and we felt it was unnecessary, and they was understanding that if the employee do not hear anything, he is okay. Anything would be abnormal, he would hear.

25 Q. Later on...?

A. Later on, well...

Q. ...they got all the reports?

A. Only, I think, asbestos there was an exception. The silica and other plants, we still maintained, if there was no report, this means good report.

30 Q. But with respect to asbestos...?

A. I think because they became more vocal, I





A. (cont'd.) presume, and they wanted those reports so we just complied with their desire.

Q. Whose desire?

A. The workmen, the employees, and maybe unions. Whoever requested.

Q. Did you ever send the results of an examination on an employee to the employee himself?

A. No, we never did this thing. I strongly resisted doing this thing, because this would be against Canadian or Ontario medical practice, ethics.

My job was to inform the family doctors, and the family doctor's job is the contact the patient and tell him bad or good news.

That is the practice in Ontario, that is the practice in private practice and we maintained exactly the same ethic.

Q. What if the employee didn't have a family physician?

A. If the fellow didn't have, they have to contact the employee and urge him to find a family doctor.

Now, if the employee would come to my office directly, so I would discuss with him and tell him and do everything. But there was still, I guess, the same Ontario ethics, medical practice, that we in some specialties, we reporting to the family doctor...the same do all consultants in Ontario, the same do all radiologists in Ontario, the same do all labs in Ontario. They report the results to the referring doctor or the family doctor.

Q. Can I ask you whether you yourself, as a medical doctor - leaving aside your role as an employee of the Ministry of Labour or the Ministry of Health - did you as a medical doctor feel any obligation in your capacity as doctor, to



Q. (cont'd.) the employee, who presumably might  
5 be considered your patient for the purpose of whatever examination  
you conducted?

A. Well, see, unfortunately, I was a consultant  
and I acted in this capacity.

Now, if the employee would come to me in my  
office, I never...I always discussed with him because they  
10 was directed to me.

Another way, I would act behind the back of the  
family doctor. This is medically...medically is unethical.

Q. So that it would require the employee actually  
having to come to you and make an appointment with you to discuss  
the matter?

A. Well, generally I was very informal. He just  
15 need to come over and I was talking, I was showing him films  
and everything.

But other way, I think family doctors would  
object if I would step in and take their place and start  
acting.

Q. Did many employees actually come to see you  
20 personally?

A. Not many. But those being concerned, I was  
glad to see them.

Q. Did you send any of the examination results  
to the Workmen's Compensation Board?

A. At the beginning we did not send, but later  
25 on we felt that the Workmen's Compensation Board, because the  
claims was coming in, should be informed, and we used to inform  
Dr. Stewart, I think.

Q. You used to send him copies of the examinations?

A. Send a copy to the Board, because he was  
30 dealing directly with employees.





Q. Tell me this, Dr. Vingilis, did...when the employee submitted himself or herself to an examination, did that employee sign any consent form or any direction which would authorize the sending of the examinations to any of the persons that you mentioned? That is, either a company physician or his own physician, or the WCB?

A. At that time we not been so legally or so confronted, and I felt that the family physician...that the physician who is dealing with the patient should have information.

Now, this report to Workmen's Compensation, I have to admit they not been regular and it only developed in later years when more and more cases appeared before the Board.

Just was the reason was the Board could handle easier. I felt if an employee goes to the Board and says, I want to establish a claim, the Board was in no position to accept or reject this claim. But when the physician at the Board had my report and they knew that there was abnormalities, for them it was much easier to handle with less bureaucracy or less red tape.

And I assumed that the Board's physician never misused this information.

Q. I take it the employees didn't actually know that that report was going to the Board?

A. Well, I not aware. Maybe they did not, maybe they know. I don't know.

Q. Well, can I ask you whether you or anybody else on your staff regularly would tell them that? I mean, would anybody tell them what was happening to the results of their examination?

A. I personally have not that much contact with the employees, because I saw the films and I send the report, and if the reports would go to any layman, naturally there had to be written agreement for the employee. But I felt that the



A. (cont'd.) medical profession, it was not necessary.

5 In those days, that was accepted practice in Ontario. Only now in recent, I think five, six years, they are getting more touchy and the doctor defends himself a little, not disclosing information that easily.

But in that time, there was no problem.

10 I can give example: If I need a film from Toronto General Hospital to compare with mine, I used to phone General Hospital and they used to send me the films of the employee, without asking whether they had the right to send to me.

15 At present time, I think it is a little different. We need permission even to find out this information, but this just happened in the past, I say, five or seven years.

Q. When you sent reports to the WCB, did those reports carry with them a recommendation as to whether or not a claim for compensation should be instituted?

20 A. Yes. The main purpose, it was, this report in sending them, to recommend a claim or recommend maybe rehabilitation or recommend other things.

But this, naturally, was just my personal recommendation, but in no means binding to Compensation Board.

25 Q. Do you have any knowledge one way or the other as to whether the Compensation Board, on its own initiative, would act on your recommendations in cases where you suggested a claim should be made?

A. I just can reply this way, that a few claims I recommended turned out later on my table.

Q. On your table as a member of the advisory committee?

30 A. Yes, advisory committee. But that, I think, has to be asked of a Compensation Board physician.



Q. You don't know whether those claims were initiated by the Board or by the worker himself? Or do you?

5 A. I presume been by the physician, some by the man himself, some by the Board.

Q. Did this practice that you have, this pattern that you have been telling us about for the last five minutes, about what you do with the reports, would that apply, for example, if you looked at an x-ray and saw evidence of a tumor, malignancy?

10 A. In asbestos case, yes. Because we considered the tumors in asbestos-exposed worker was compensable disease. But if they would be in, like, say, silica-exposed worker, we would not. We would not bother informing Compensation Board because we know this is not a compensable disease.

15 Q. I may not have made my question clear, but suppose you looked at an x-ray film of an asbestos worker and you saw what appeared to be a mesothelioma, would you not contact the worker in that case, directly?

20 A. Oh, that would be...even by telephone. I would not trust the mail. I would contact straight by telephone.

25 But mesotheliomas and tumors, you do not alarm the employee because is only suspicious diagnosis. What we have to do, we refer for further investigation - a lung biopsy, for admission to the hospital, pleural expectorations examined microscopically, and then when diagnosis is definitely established, then do we prefer that the family doctor contact the man in a nice, appropriate way, ethical, maybe psychologically, using psychology, tell him the bad news.

30 I avoided to tell the man straight in the face. First thing, because it may be just plain pleurisy, not mesothelioma, and you causing the man unnecessary anxiety for





A. (cont'd.) too many months. A tumor may be just some...not malignant.

5 In the case of abnormal chest x-rays, I always pass the message, the man was informed...I even can repeat the phraseology - that abnormal changes been seen in your chest x-ray film, please contact your family doctor and he will proceed from there on.

10 Generally the family doctor, after they are admitted in the hospital, want to refer to a surgeon, or so on. I directly avoid to be directly involved. I like to be behind, in the background.

Q. I take you weren't actually out at the plant doing the x-rays? You were...you had technicians who were out actually doing the field work?

15 A. I never been in the plant.

Q. You yourself have never been in the plant?

A. No.

Q. That includes the Johns-Manville plant?

A. I been in many other plants, but not Johns-Manville.

20 Q. You've never been in the Johns-Manville plant.

Can you, looking back on the program over the thirty years you have administered it, can you help us and give us some assessment as to what the reaction of the workers, indeed if there were unions involved, the unions, to this program that you were administering?

25 A. I had very frequent contacts with the union leader, and he always been very cordial and we never had any disagreement. If I ask him something to do, he ask me something to do, we always get very amicable solutions.

30 Q. Did you receive any complaints about the manner in which the program was implemented or administered, over time?



5 A. Not directly complaints. He asked me to something, do him this favor. If it was within my ability, I used to comply.

Q. Were there any changes or, from your point of view, improvements made to the program?

10 A. Sometimes we did discuss, when we introduced, for instance, six months survey and/or lung function tests, I discussed with him.

Q. Were those, in your view...

A. They were with the union leader, Mr. John Neilson, I think his name is.

Q. What about the employees themselves? Did they ever voice any concerns about the program through the years?

15 A. Not anything unusual, no. I think more or less they been satisfied, because we used to get good co-operation regarding x-ray and lung function tests.

Now it would be a different story when we saw them for assessment of Compensation Board. That was maybe a little different feelings.

20 Q. I'm going to come to that in a minute. That's in your role on the advisory committee?

A. Advisory, yes.

Q. Is there any program of post-employment surveillance, conducted by the Ministry?

25 A. Well, our program at that time, I felt that we do pre-employment examination, we follow the man during his working years, when he develop disease our duty is to follow him as long as he lives, and we maintain this attitude and we try to carry this problem as to our ability.

30 Now, when the man left employment without occupational disease, we always wanted to see their x-ray and they been always welcome to come to us for free x-ray and





A. (cont'd.) free examination.

Those that live in the Toronto area, they take this advantage. But unfortunately, many moved in far away places and naturally they been lost.

Q. How did you communicate the availability of this examination after employment? Was there some systematic program to notify employees? Exemployees?

A. I think the health department of Johns-Manville could make a better reply to this question, but our service was well advertised, the dates when we been in the plant, and I assume that the medical department tried to contact exemployees to participate in this service, even if they been laid off...laid off or resigned or quit.

DR. DUPRE: When you say you assume the medical department invite the exemployees, are you referring to the medical department of the plant?

THE WITNESS: Of the plant, yes.

MR. LASKIN: Q. What about the unions? Did you seek the assistance of the unions in trying to track down exemployees?

THE WITNESS: A. Not directly Canadian Johns-Manville, but with the ladders union we deal strictly with the unions.

Q. With the insulators?

A. Insulators. Because we arranged a service to them and we contact...all contacts went through the unions. Otherwise, it would be hard to handle.

Q. I'm going to come to that in a minute, but do I take it you are talking about Johns-Manville or any other fixed-site plant, you basically relied upon the company's own medical department or health department to trace these exemployees?

A. Yes. I presume...

Q. Is that right?



5 A. I presume...my assumption is on this regard, because I used to read the films and I knew those people not been working with Johns-Manville. I know they arrived to the plant purposely...for the purpose of being examined. But that is...my knowledge ends here. How they been contacted, I'm not aware.

10 Q. Does your answer hold true up to the very time that you left the Ministry? I mean, up until this year? Is there any more systematic program of surveillance of exemployees that's in place now, do you know?

15 A. No, I think it's about the same. When the mine was closed, remember, the mine in Northern Ontario, we tried to contact those people. We advertised, even, through the radio and the press and so on, to warn them and that they either should avail themselves of annual or biannual examinations.

How much success this was, I don't know.

20 Q. Do you have any idea, or do you know whether the Ministry kept statistics on how many exemployees were availing themselves of this opportunity for examinations?

25 A. No, I think...I'm not aware. I don't think there is any statistics how many availed...because they are extremely difficult to contact.

DR. UFFEN: Can I ask one...

MR. LASKIN: Sure.

25 DR. UFFEN: If an employee had become ill, left his employment and took a job someplace else, would you have any way of recognizing his case when it came...say it came before you again in a routine fashion, in his new employment?

THE WITNESS: We did not know him before.

DR. UFFEN: I beg your pardon?

30 THE WITNESS: I say we didn't know about him before. He was not sick when he left employment.



THE WITNESS: (cont'd.) That's the question?  
He left, for instance...

5 DR. UFFEN: The question is, if he was sick...

THE WITNESS: If he was sick, then we would  
never lose him. He would be on our records.

DR. UFFEN: How would you keep track of him when  
he left one job and went to another?

10 THE WITNESS: This was very nicely arranged. We  
used to file the claims with Compensation Board, and the...he  
had a claim, although he maybe was not sick, he may not be  
compensated, but the claim was active and we used to follow  
him annually and try to contact where he was.

15 If we could not find him we used to phone  
Compensation Board and they used to trace the man. Any  
exemployees that had changes in chest x-ray, however minimal,  
we kept track of them all the time. We are still keeping track.

DR. UFFEN: Even if they left the country?

20 THE WITNESS: Well, if they leave the country,  
if you have a claim - say he is getting ten percent, minimal  
ten percent compensation, yes, we still keep track and then we  
request a good examination locally - like British Columbia or  
Los Angeles, by local doctors...and send us x-ray films, send  
us medical reports and a lung function test, and we try to  
assess according to the doctor who examined the report and  
recommend a claim increase, or whatever.

25 They never lose those, they have that minimal  
change. The problem is, those who leave with a clear chest.  
Those, I think, they been lost and they can develop later on.

30 Now, I think Compensation Board advertised  
to all practicing doctors that if you suspect occupational  
disease, do file the claim. So we did see a few claims  
later on and accepted, they left plants ten, fifteen years ago  
with clear chests.





MR. LASKIN: Q. Was there any similar program of examination for chest disease in the...I'm going to call it the construction site, the nonfixed-place work sites?

THE WITNESS: A. Regarding asbestos?

Q. Regarding asbestos.

A. Yes, well, I think here there was only the insulators. Now, insulators, we did big efforts to trace them and follow them and x-ray them, but here success was much... percetagewise, much less lower than Johns-Manville or the companies Raybestos Manhattan or others.

Q. Much lower?

A. Much lower, because, well, they so spread around and the lagger is considered somewhat self-employed, and a completely different psychology is there. We had much difficulty to coax them to appear to us.

Q. They were more resistant to submitting to examinations?

A. I would say more ignorant. I guess they feel the same for self-employed, and just a different psychology, a different people there. But those appeared, they be nice and we choose to accommodate Saturdays in union halls, because on the work site was bad. The unions used to get the letters to come to union halls Saturday, we are not working, and you go there Saturdays and try to examine them.

Q. Is this the area where you tried to use the assistance of the unions?

A. This was strictly through the unions, yes. Unions been very, very co-operative. Unions been very annoying to stay-home employees because they didn't comply to their request.

I remember I talked to many union leaders. They just been really blue because the employees wouldn't listen to



A. (cont'd.) them.

The union leaders realized much more clearly danger than the individual lagger, I presume.

Q. Which union are we talking about?

A. I think there was numbers...Union Local 95 and Union Local something-56, or something. Two numbers stick in my memory.

Q. The Frost Insulators?

A. Well, for some reason those names didn't go on our cards. Was the local, Asbestos Local 95.

Q. I see.

A. One was there, and another asbestos local in Windsor area...not Windsor, in Ottawa area, was different numbers. Is it fifty-six, sixty-four, something?

Q. The Heat and Frost Insulators and Asbestos Workers?

A. This name don't click with me, because it was not on our records.

Q. All right.

A. But I think that's exactly what you...

Q. Can you tell me this, it's perhaps too general a question, Dr. Vingilis, but looking back over the thirty years which you administered this program, what do you see is the benefit, if any, of the program, to the workers, and specifically asbestos workers?

A. I think the biggest benefit the we realized, that asbestos was dangerous dust, and most likely next thing we realized, that the dust count in the plant maybe was higher than it should be.

I think any medical surveys programs are...that's the purpose, to see whether the dust or toxic materials that is inhaled is severely toxic, and whether it produces disease.



A. (cnt'd.) Now, what other reasons - whether we help directly the employees...this is really difficult, this more would be philosophical question.

If you ask question how many lives we saved by our surveys, few cases we diagnosed cancer earlier. I guess they still could be operated and still alive. A few cases we diagnosed and they left employment. Now, whether it is leaving employment is relevant, there is different opinions. Some doctors think that it's irrelevant. My opinion is still that if you leave employment earlier, or you are exposed to less dust, maybe there is some benefit. But this is the thing, because you heard many expert witness, it's very debatable and very questionable whether early removal from exposure is beneficial to the man.

Q. Were you giving any recommendations to employees...

A. Yes, I personally give recommendation.

Q. As to whether they should leave employment?

A. Yes, leave employment. But there are many good authorities saying that it's irrelevant.

Q. No, but when you were, for example, reading x-rays of Johns-Manville workers, did you give any recommendations through the worker's family physician as to whether he should employment at Johns-Manville, for example?

A. I qualified this recommendation according to the man's age. If the employee was something between sixty... fifty-five, sixty years old, he was already working for twenty-five years, I did not see much reason to remove him from his employment. I doubt whether there would be much difference in his health. Naturally, his financial, economic way of life would be disturbed.

If they would be young men - say forty, forty-five, I strongly recommend that the man should be removed and retrained.





A. (cont'd.) I think it was very well accommodated by the Workmen's Compensation Board.

5 But I guess there is some good authorities think that this is really irrelevant.

Now, this is different with silica, if you go with comparison. I can...I know if you remove silica, if it's very early stages of exposure, it's not likely...you would progress for a few years, maybe five, six years, then later get stabilized and do not progress further.

10 With asbestos, I leave the question open.

Q. All right. Let me ask you some questions about your role on the advisory committee on occupational chest disease.

15 DR. DUPRE: Just before you go into that, counsel, can I just ask one question, if you please, Dr. Vingilis?

You have described your role in the x-ray and lung function tests that were given to asbestos workers from 1952 on.

THE WITNESS: Mmm-hmm.

20 DR. DUPRE: Now, do I understand correctly that none of this program was compulsory under either legislation or regulation?

THE WITNESS: Yes.

DR. DUPRE: It was a voluntary program?

THE WITNESS: Yes.

25 DR. DUPRE: Now, do I further understand correctly that the program therefore depended on two things - first the volunteering of the company concerned, and then secondly, the volunteering of the employees themselves?

THE WITNESS: Yes.

30 DR. DUPRE: Do I further understand correctly that as near as you can estimate it, you are satisfied that the x-ray



5 DR. DUPRE: (cont'd.) and lung function tests for asbestos workers covered eighty percent of the Johns-Manville employees, or eighty percent of all asbestos employees?

THE WITNESS: The question raised this, to each survey how many employees we used to survey at one year, at one time. I would say around eighty percent.

DR. DUPRE: At one year, at one time at one plant?

10 THE WITNESS: At one plant. Next year we used to catch those absent, so I think Johns-Manville practically we had a hundred percent, or close to a hundred percent.

DR. DUPRE: But of course there was no way that you could mandate one hundred percent because there was no legislative authority to mandate?

15 THE WITNESS: But I think the Johns-Manville employees, they volunteered. There was very good attendance and friendly relations, and eager to be examined.

Similar, I think, was in other bigger industries.

20 DR. UFFEN: Was there anywhere you didn't get good co-operation?

THE WITNESS: Well, I would have to say insulators, whether they just not been available or many other reasons.

25 Now, there been many little plants, they not been aware probably. But anywhere we spotted asbestos exposure and we approached, the companies always volunteered. There was not a single case where we were turned down, and the workers also volunteered.

Later we introduced even the talc, because talc contains tremolite fibers, and we went even talc plants and paint plants and extended in all directions.

30 DR. DUPRE: So from your experience then, can I take it that it would be your educated estimate...let us put it that way...that at such time as these tests were carried on at



DR. DUPRE: (cont'd.) any of the larger asbestos plants, about eighty percent of the employees will be tested?

THE WITNESS: Yes.

DR. DUPRE: The twenty percent falling out not because of lack of willingness to co-operate , but because they were absent on the days when the tests took place?

THE WITNESS: But we used to catch next year, and we felt that it was nothing unusual as asbestosis do not develop in one or two years. You skip one year, you catch them next year, so that it felt perfectly fine.

DR. DUPRE: I see. For that reason, then, you didn't feel it necessary to try to immediately follow up on the twenty percent that did not show up?

THE WITNESS: No.

DR. DUPRE: I see. Thank you.

Thank you, counsel.

MR. LASKIN: Q. Just perhaps a couple of followup questions. To take Johns-Manville, was your program of examination, so far as you were aware, the only program that was administered to the employees of Johns-Manville, or did the company have its own internal examination program for its employees?

THE WITNESS: A. I wouldn't be able to answer this question.

Q. From the perception of the Ministry, am I correct that the Ministry saw the program that you administered as being one, in effect, a service for the company? Is that putting it fairly?

A. It was a service for the employees, not the company.

Q. Did the company have to request it? I mean, how did the program get instituted at a particular plant? Did a company have to request it?





5 A. Yes. I think our organizer requested the company that you have hazardous material, whatever hazard there is, and we would like to introduce a survey, and companies always welcomed our survey.

Q. Did the companies pay for it? Did the companies pay for your service?

10 A. No. No, it was from tax...well, government service, taxpayers' money in other words.

Q. But individual plants did not pay a particular fee in order to avail themselves...

A. No.

Q. ...of your particular...

15 A. No. In silica exposure there was one dollar fee for issuing health certificates. That was administrative fee only, but not for medical services.

Q. Was there a particular doctor at Johns-Manville to whom you used to send copies of your report?

A. Yes. In early days, Dr. Corson. Late on...

20 Q. Dr. Corson?

A. Dr. Corson, and later on, Dr. Doakes.

DR. DUPRE: Dr. Corson, C O R S O N?

THE WITNESS: Is this the way? I don't have direction here.

25 MR. LASKIN: Q. Was he actually an employee of Johns-Manville, or was he in private practice and retained by the plant?

THE WITNESS: A. I wouldn't be able to tell you.

Q. You don't know? All right. Who was his successor? Dr...?

A. Dr. Doake, Doakes. Dr. Doak.

30 Q. D O A K?

A. D O A K, Yes.



5 DR. DUPRE: One other question along that line, Dr. Vingilis. You have mentioned that in the case of exemployees the medical department of the plant would have to take the initiative in terms of whether they would be identified to you.

Did you regularly deal with the medical department of any of the major plants, with their medical officers in particular?

THE WITNESS: Yes.

10 DR. DUPRE: At the J-M plant this means that these individuals would have been Dr. Corson or Dr. Doak?

THE WITNESS: Yes.

DR. DUPRE: Well, just one followup on that.

15 In your dealings with the medical department of such plants, did you feel that you sometimes could benefit from exchanges of information, given the experience that the medical officers of such plants might have with employees who were subject to asbestos exposure?

20 THE WITNESS: I think we had a couple of meetings with Dr. Corson and with Dr. Doak, discussing problems and the feasibility of surveys, or maybe modification of the surveys. Yes, from time to time.

25 DR. DUPRE: In such meetings, do you recall the extent to which the individuals from a multinational like Johns-Manville, to whom you were speaking, might perhaps have the benefit of information and research advice that came to them from headquarters?

THE WITNESS: Dr. Smith, I think, he was...

MR. LASKIN: Dr. Wallace Smith.

THE WITNESS: ...he was corporate director, he used to visit us occasionally and...

30 DR. DUPRE: This was the...

THE WITNESS: ...this was in about the sixties.



DR. DUPRE: This would have been the medical officer from Denver?

5 THE WITNESS: From New York, yes. He used to discuss and he used to give us information about, you know, the States. We used to tell our grievances, and then I think one time I met Dr. Paul Kotin. When Dr. Paul is present, he visit us about three years ago and we discussed the same problems.

10 MR. LASKIN: Q. What would you talk about? Would you get some advice and instruction on the detection of disease, for example, asbestosis?

THE WITNESS: A. No. I used to demonstrate them our program. I used to demonstrate them our films, I would demonstrate how we survey the plant, ask if they are satisfied with our records, and I sometimes maybe get ideas.

15 They, I think they been interested to see how good we are, our proceedings and how this all happens.

DR. UFFEN: I'm a bit curious about reading the x-ray itself. If the disease is progressing, there must be a stage where no evidence, and then when the evidence is clear. In between there must be a time when you are not sure.

20 THE WITNESS: Yes. There is grey area, yes.

DR. UFFEN: How do you describe it? Is there a nomenclature or systematic classification that one physician would understand what another physician has recorded?

25 THE WITNESS: Well, it is true, asbestosis is progressing very imperceptibly. There is no white and black, it's a big grey area, and I realized this very soon after I started working with the Ministry, and I introduced such terminology - the possible effect of asbestos dust inhalation. I guess you heard this terminology.

30 There is no asbestosis yet, but I felt it was not quite normal, too. So this was nondiagnostic, nonspecific.





THE WITNESS: (cont'd.) We used to put like a flag, we have to put even tag on them and we have special code number. So then I see next year I look much more carefully and see whether it is the progress. That is this grey area in the lung changes...the same in the pleural changes, and that is true, there is this grey area. And they got to be watched a year or two years and see whether...many other little diseases can imitate the same, and then you just...sometimes we used to say I want to see the man in three months time, or in six months time, and the plant used to send to us for another x-ray.

DR. UFFEN: Did you consult another physician at that stage?

THE WITNESS: Oh, yes. There was free exchange.

MR. LASKIN: Q. When you examined these employees, did you, or did somebody on your staff, take any sort of work history?

THE WITNESS: A. Yes, we had work histories. When a technician goes in the plant, if it's a new employee he always asks for occupational history. That was the prerequisite.

Q. Did the occupational history carry with it any exposure measurements for particular employees as to what level of exposure they may have had?

A. No. They just asked, did you work in an exposure area before, when you started work in the exposure area, did you work in the mines at all, did you work in asbestos, say, in British Columbia, and when and dates.

Q. Did your branch have any dust measurements whatsoever?

A. That was different, engineering branch. Engineering branch at the...at that time they been in completely different part, and we have nothing to do.



Q. Were they made available to you?

5 A. They used to send...I requested, they used to send us copies of the engineering report, for our files. That was for any file, because if I see unusual film, I like to know what the man exposed to. I used to go in our blue file, pick the file that I need, what the plant used, what dust is there, what chemicals is there, so I get an idea of what the man was exposed to.

10 But yeah, that was including dust counts. But we have no power, neither, directing for that. Sometimes, yeah, well, if I can extend it further, if I noticed that for instance one plant is more occupational disease than I would expect, I used to phone or send a note to the engineering department to go and see what is going on...if I see more  
15 disease than I like to see.

Very often it had been that way, that the company had just hired employees from different parts of the world, they had been already exposed to disease.

20 Q. In your recollection, can you put a date on the first time that, in reading an x-ray film of a Johns-Manville worker, you saw evidence of disease?

A. The first case of asbestosis?

Q. All right. Let's take the first case of asbestosis.

25 A. I think it was 1964 or 1965, but I just say from my memory. This can be verified in the files. This could be a year or two years different.

And we been very concerned, we did a lung biopsy and the slide travelled four or five times from Canada to America for all experts to just see what is there.

30 This case was very interesting case because he had two diseases, and to start it was asbestosis.



Q. I'm sorry?

5 A. This case was very interesting because he had two diseases - sarcoidosis, plus asbestosis. That's why most expert pathologists had difficulty to diagnose it.

We used to get one internationally-well known pathologist say that's a clear sarcoidosis, and you get from another one says it's clear asbestosis. It's very interesting, very first case, was two diseases.

10 Q. You're going to have to slow down. What's the first...we got asbestosis, what's the...

A. But eventually he had asbestosis. He had two diseases.

Q. What was the other disease?

15 A. Sarcoidosis. That is nonindustrial disease. It just happened to that guy.

DR. UFFEN: But it's a lung ailment?

THE WITNESS: Lung ailment, yes.

MR. LASKIN: Q. And that, to your recollection, was the first...

20 THE WITNESS: A. The very first, yes.

Q. ...case of asbestosis that you observed at Johns-Manville?

A. At Johns-Manville.

25 DR. UFFEN: Pardon my curiosity. What would it be about these two ailments that made it so difficult to decide which was which?

THE WITNESS: I think pathological changes are very similar, and the one is leaning toward sarcoid, the other was leaning to asbestos.

DR. UFFEN: What causes...

30 THE WITNESS: The similarity of pathological abnormalities in the slides.





DR. UFFEN: But is there any single recognized cause for the other ailment - I can't pronounce it.

THE WITNESS: Well, if they would be strictly sarcoid, I guess, the pathologists recognized sarcoid. But there was a mixture of the two, and there just was something between sarcoids and something between asbestos.

DR. UFFEN: What I meant is, if a person had...

THE WITNESS: Sarcoidosis only?

DR. UFFEN: ...sarcoidosis only...

THE WITNESS: Oh, every pathologist would recognize. We would not need...

DR. UFFEN: What would be the cause of it, dust?

THE WITNESS: No, no.

DR. UFFEN: Chemicals? Old age?

THE WITNESS: No, sarcoidosis is disease by itself. Even young people can get and old people can get. Is nonrelated to any dust exposure. It's an autoimmune disease, generally selfcontrolled, generally improved. You put them on steroids. Is common disease. Is nothing new.

DR. DUPRE: Maybe you could spell that.

THE WITNESS: Sarcoidosis.

DR. DUPRE: S A R C O I D I S I S? (sic)

THE WITNESS: That's correct.

DR. UFFEN: I'm sorry I'm slow. I still haven't got the idea of what causes it.

THE WITNESS: Sarcoid...what this means, there is no known cause. There isn't anything...

DR. UFFEN: Okay. No known cause. All right. That I understand.

THE WITNESS: Somebody incriminated that from the pine trees falls, it flows in the air, inhaled, because there is more sometimes in Scandinavian countries. But no cause,



THE WITNESS: (cont'd.) nobody knows the cause.

MR. LASKIN: Q. Dr. Vingilis, did you see any evidence of silicosis amongst Johns-Manville employees, prior to 1964?

THE WITNESS: A. Yes, I think the very first two cases that abnormalities showed up, it was predominantly silicosis.

Q. Not asbestosis?

A. Not asbestosis, radiologically.

Q. I take it radiologically there is a distinct difference between...

A. Is a distinct difference, yeah, because silicosis is a benign disease. But for some reasons, later silicosis faded away and we didn't see more silicosis. I presume dust was controlled, and for silica you need higher concentration of dust.

Q. What, in your recollection, is the first time you saw a malignancy out at Johns-Manville?

A. I can't remember.

Q. You can't remember? Before or after 1964, can you tell us that?

A. I have to...we prepared annual reports and now if somebody really wants to know the names and numbers, everything, every year I prepared very comprehensive reports and sent to my director, including the cases of asbestosis, preasbestosis, suspected asbestosis and malignancies.

At the end of the year every director got this report.

Q. When you say the first case of asbestosis was 1964...

A. Around there.

Q. Around there, all right. Were there any



Q. (cont'd.) suspected asbestosis cases or preasbestosis cases, as you call them, prior to that time?

5 A. Well, I think I should look in the files. I couldn't quote from memory.

Q. You have no recollection of that?

A. I'm afraid to say.

10 Q. Let me turn to your role on the advisory committee on occupational chest disease. Do I understand it that you are, while you were at the Ministry of Labour you were one of two ministry employees on the advisory committee?

A. Yes.

Q. Who was the other one?

A. I think it was Dr. Cowle.

15 Q. Cowle?

A. Yes.

Q. C O W L E?

A. He is deceased now.

20 Q. Is there at the present time another ministry..

A. Yeah, is now Dr. Roos, R O O S.

Q. Sits on the advisory committee. And how many members are there on the advisory committee right now?

A. How many? Six or seven. How many members?

UNIDENTIFIED SPEAKER: Six.

25 A. Six, yes.

Q. And is there a chairman?

A. Yes, Dr. Rorabeck.

Q. Dr. Rorabeck?

A. Dr. Rorabeck.

30 Q. I take insofar as the Board is concerned, your role is dealing with basically asbestosis claims?

A. No.





Q. No?

A. Any occupational disease.

Q. All right.

A. Any occupational chest disease.

Q. Does that include the cancers?

A. Well, I think at present time the cancers are not directed to us because Compensation Board, according to the different laws, they deal directly. We are dealing only with the cases that are doubtful, diagnosis doubtful, or those that need assessment for partial disability.

Q. I'm sorry.

A. Oh, we seeing only...not all cases the Workmen's Compensation Board refers to us. I presume those cases they are either doubtful diagnosis or they need assessing of disability, or percentage of disability.

Now if the man is hundred percent disabled and Workmen's Compensation Board knows he is one hundred percent disabled, they don't bother sending to us. They dealing directly.

That's the way? Yes.

I know only that much - they direct to us to examine the cases, and we examine.

Q. Is it...

MR. STAKRMAN: Mr. Chairman?

DR. DUPRE: Yes?

MR. STARKMAN: Before we go on, I would like the record to indicate that this witness is consistently seeking conformation of his answers from someone sitting in the audience. I'm not sure what confirmation he is seeking, but these are questions that are being asked of a fellow who has been employed by the Ministry for thirty years, and has been sitting on the advisory council, and when he is asked a question



5 MR. STARKMAN: (cont'd.) about how many people sit on the advisory council and who the chairman of the advisory council is, he seeks confirmation of that answer from someone in the audience. I think that he should be directed to refrain from doing that, because if he knows the answer he should state it, if he doesn't, then he should say so. But he shouldn't seek the answer from someone in the audience.

10 I think there is a real question here not just of getting the information before the Commission...that will come out. But there is a real question of the type of people that are sitting on these bodies, and what they know and what they don't know, and I don't think that this witness should be allowed to seek general advice from...I don't even know who he is asking. I know he is gesturing down this way and  
15 nodding his head, but I don't really know what's happening. If we are going to have more than one person, perhaps we should proceed in that way.

20 DR. DUPRE: Thank you, Mr. Starkman. Your intervention, of course, will indicate on the record, that the witness has been looking to the audience to have his memory prodded.

25 May I, Dr. Vingilis, ask you please to simply try to answer these questions to the best of your own recollection and ability, and if we need to fill in the record, we can proceed in due course.

THE WITNESS: Okay. I...

30 MR. LEDERER: Mr. Chairman, I wonder if I might just make a brief comment in response to what Mr. Starkman just said. I don't in any way question your comments to Dr. Vingilis, I think they are entirely appropriate. However, there seems to be a suggestion in the way that Mr. Starkman has approached this that Dr. Vingilis doesn't know the answers. I would



5 MR. LEDERER: (cont'd.) take it from the way  
this past conversation has gone on that in fact there is no  
demonstration that Dr. Vingilis doesn't know the answer. On  
the contrary. His motivation, the way I read it, is to be sure  
that this Commission gets a complete and a fair answer to the  
questions that are being asked, and if there is any suggestion  
that he didn't know the answers, I don't think, at least at  
the moment, that that's a fair implication and shouldn't be  
10 drawn from what has transpired to this point.

DR. DUPRE: Thank you, counsel. I think that  
my own remarks indicate that I interpreted Dr. Vingilis's  
consultations as simply a matter of refreshing his own memory.

MR. LEDERER: Thank you, sir.

15 THE WITNESS: So if I'm not a hundred percent  
sure, I say...

DR. DUPRE: Then just say so, and we'll...

THE WITNESS: It's only a little guessing...

DR. DUPRE: Fine.

20 THE WITNESS: ...because this was guessing.  
The members are varied from six to seven during the years, and  
I was not so sure I could say, I don't know.

Okay.

DR. DUPRE: Thank you.

MR. LASKIN: Q. Particular cases then, I take it,  
are referred to the committee on which you sit..by the Board?

25 THE WITNESS: A. I said the number of members of  
committee did change during the thirty years, so my reply would  
be, I don't know.

Q. I'm sorry. You may have misunderstood my  
question. I just want to ask you about the cases that you get,  
and I take it from your previous evidence...

30 A. Oh, cases we get from Compensation?





Q. ...that they are referred by someone at the Board?

A. Yes.

Q. Is that someone Dr. Stewart? Is your liaison?

A. Dr. Stewart, Dr. Dyer.

Q. They are the two people who are basically responsible for referring particular...

A. The referrals, yes, to us.

Q. When they refer particular cases to you, do they refer them with a question or a particular set of questions that they are asking the committee to give its recommendation on?

A. No. I think they collect all information relevant to the case, just to make this process a little shorter, they try to arrange all films possible, they get the files from the company, they get a statement from the employee, and send anything what is in their possession to facilitate to assess the case properly, and then from our side we try to get maybe more information. If you find from the person that x-rays is still available from other hospitals or another doctor, we make them available to us.

Q. When you get a particular case, has there been any preliminary diagnosis of that case done by anybody?

A. Generally, yes.

Q. By whom?

A. Maybe family doctor, maybe by us, maybe by plant doctor.

Q. Is then one of your functions to verify the diagnosis?

A. Yes, that's correct.

Q. In doing so, does any member of your committee actually examine the patient, the worker?

A. Yes.



Q. A particular person, or whoever is available.

5 A. Well, no. Well, there is a roster and a different doctor examines on different days.

Q. I see. And does that particular doctor do the whole array of tests, x-rays, lung function tests and so on?

A. Yes.

Q. Lung biopsies?

10 A. Well, if he thinks it's necessary, then we refer to the hospital to do the lung biopsy.

Q. All right. Do you then address yourself to the question as to whether or not there is an occupational disease?

A. Yes.

15 Q. And also the question of percentage of impairment, I take it?

A. Yes.

Q. Are those the, generally speaking, are those the basic issues that your committee deals with, that is, verifying the diagnosis, looking at the question as to whether the person is disabled from an occupational disease, and...

20 A. Yes.

Q. ...thirdly, looking at the question of percentage impairment?

A. Yes.

Q. Are there any general issues I've missed?

25 A. Well, if we find any other disease relevant, naturally we bring attention to it.

Q. That may not be occupationally...

A. Not occupational.

Q. ...you'll still raise it?

A. Still raise it.

30 Q. All right. I want to spend a few moments on those issues, and let's talk about the question of disablement



Q. (cont'd.) from occupational disease, and let's...perhaps we can deal with asbestosis claims by way of example.

What is your committee looking for in terms of exposure or work history in order to make an assessment as to whether a particular fibrosis that an individual may have is occupational disease by way of asbestosis?

A. I think we get the histories generally from the very beginning. You ask the man when he finished school, and from there we going step by step, year by year, what he did until the day of examination. We ask where he was exposed, what place and what job he did and so on. We get very comprehensive history, and then we do a very comprehensive physical examination. We take x-rays, bilateral, we have x-rays, we secure all x-rays available every made of the man elsewhere, and then we do a very comprehensive, particularly in new examinations, lung function test, and we are doing stress tests, including cardiovascular and pulmonary stress test, and we compute all data and then every Tuesday, generally, we have all members meeting and the case is represented, discussed and decided whether the man has an occupational disease...if he has, what's his disability, if he has disability, what's his percentage of disability.

Then they report this...

Q. Let's just break this down. Let me tell you what my problem is in the first part.

The Board, as I understand it, has published certain guidelines with respect to asbestosis and as I understand it there are at least two criteria. Number one, there has to be a clear and adequate history of occupational exposure to asbestos, and second, there has to be a diagnosis of frank asbestosis.





Q. (cont'd.) First of all, I should ask you are you familiar with those guidelines, those criteria?

5 A. I think there has to be a history to exposure...

Q. No, just a minute. Just tell us first of all whether you are familiar, or you know about those two guidelines?

10 A. Those guidelines never impressed us directly, but that is automatically assumed there has to a history of exposure. If there is no history of exposure, I presume automatically it cannot be asbestosis.

Q. But what I'm trying to get at, Dr. Vingilis, is how much of a history of exposure would be sufficient to satisfy your committee?

15 A. No, I don't think there is no medical number of exposures we are referred to, no. There is no such as one year or two years or three years. No, there is no such a thing with regard to asbestos.

In silica there is a two year minimum exposure. In asbestos, I am not aware of that strict condition.

20 Q. But is there some rule of thumb, is there some practical guideline that your committee employs in saying anyone with, say five years exposure to asbestosis (sic) automatically satisfies the requirements for occupational exposure?

A. No, there is no such a thing.

25 Q. Would the committee, or has the committee in the past, for example, rejected claims because an employee was only employed for two years in an asbestos plant?

30 A. Well, in two years it is very unlikely that asbestosis would develop, but this is just a hypothetical question. I don't think...there have been mesothelioma case what was very questionable exposure, but we did not deal, Compensation, deal directly. There is one extensive pleural fibrosis, not asbestosis,



A. (cont'd.) developed in unknown time, but we accepted it.

5 But there is no such a number, I would say, if you are just exposed one year then you don't qualify, no.

Q. All right. If there is no number, and you've told us your committee is not overly impressed by the guidelines, tell us what your committee is looking for in order to recommend compensation in an asbestosis case.

10 A. We are looking for diagnosis, whether the man has asbestosis or not.

Q. All right. Let's deal with that. What...are there any radiological signs...

A. Yes.

Q. ...lung function tests?

15 A. Yes.

Q. That you are specifically looking for in order to conclude a diagnosis of asbestosis?

A. I think have to be minimum radiological signs first.

20 Q. What are they?

A. Have to be reticular, nodular or fibrotic changes in the lungs, have pleural plaques, calcifications either diaphragm or the pleura. They would be radiological.

25 Next thing, we will be looking for physical findings - whether we hear crackles or not crackles - we look lung function test, whether there is restrictive interdura defect, or his lung. We see how well the man can function in a stress test, and all those components eventually get the diagnosis. Whether the man worked five years or twenty years, there is really different response for different people to dust, and it is not really relevant.

30 Q. All right. The length of time he works?



A. Length of time, yes.

Q. Is not really relevant?

5 A. Not really relevant, no. But there is correlation - the longer he works, the more changes he gets, but we not going by just a rule.

Q. Fair enough. And do I take it from that that what you are principally looking for is a diagnosis of asbestosis?

A. Diagnosis of asbestosis.

10 MR. LASKIN: I'm sorry, I interrupted you before, Dr. Uffen. Did you have a question?

DR. UFFEN: No, I think you are proceeding to ask whatever...thanks.

MR. LASKIN: Q. Are these particular criteria to determine the diagnosis of asbestosis, are they written down  
15 anywhere by your advisory committee?

THE WITNESS: A. No, we just going by textbooks and reference books for the studies, and so on.

Q. All right. Is there a particular textbook or books or directive?

20 A. Not particular. I think, well, many textbooks everyday is published something about asbestosis, and we try to follow and collect all the information available.

Q. What about your approach to percentage ratings? What guidelines or criteria does the committee use in seeking a percentage...and I take it it is an impairment rating?

25 A. Impairment.

Q. Physical impairment?

A. Physical impairment.

Q. What guidelines or criteria do you utilize?

30 A. Oh, first we must establish that the man has clinical asbestosis. I mention clinical because if one does a lung biopsy and you may see few asbestos fibers, few asbestos bodies, or maybe a small number of fibrous tissue in the lung,





A. (cont'd.) this theoretically made...its connotation was asbestosis, but it's not clinical asbestosis.

5 I could just compare as arteriosclerosis. If the man reached sixty, he has arteriosclerotic plaque somewhere in the brain, but be not telling the man, you are arteriosclerotic and you out of a job.

10 I think clinical asbestosis. Okay, the man has clinical asbestosis, now we going for the function, next thing. Ask him his history, how he functions compared to another guy his age. We got his lung function test, that's a very important sign. We put him on stress test, which is very important sign. His stress test goes from three hundred KPM to nine hundred KPM. If the man can not reach only three hundred KPM, he knows that this limits for...he is limited for very light work or just maybe  
15 sedentary work.

Now, he know he is manual labourer, eventually his rating would be high. If the man can reach nine hundred KPM, he is physically not disabled. He is perfectly doing any type of the work. So this disability rating would be minimal.

20 Q. Let's see if you can maybe help us by putting it in terms that we can understand.

A. Okay. three hundred...what meant...

Q. Let me...

A. ...let's say how three hundred KPM, how much effort is...

25 Q. Let's start the other way. Let me ask you, what kind of a person would you have before you in terms of impairment in order to give that person, for example, a ten to twenty percent impairment rating?

And how employable would that person be?

30 A. A ten percent man, he would be perfectly employable on any job.



Q. And what kinds of abnormal signs or functions would he have? Could you reduce it to terms that we can understand?

A. Okay. With slight fibrosis in his lungs, maybe he has a few plaques on his pleural side, his lung function test like would be just first vital capacity, maybe in the vicinity around seventy-five, eighty. If we put on bicycle, he maybe would start difficulty by six hundred to seven hundred KPM, but we would consider that this ten to twenty percent is able.

Q. What about sort of going up and down stairs?

A. Well, this would be considering that he still could easy run to the top flight of the stairs, he still could walk against the wind five, six blocks. So he would be considered ten to twenty percent disabled.

Now, this you would fit to any industrial work, in any practical meaning. He would not need to be replaced. Ten percent up to twenty percent, the man can be employed in any capacity. This percentage is given because we think his lungs just a little damaged, his vital capacity is on the borderline, his performance is borderline, so he gets ten, twenty percent.

DR. UFFEN: I may have missed it, but what's a KPM?

THE WITNESS: How much the man can perform on the bicycle...

DR. UFFEN: Yes, but the KPM...

THE WITNESS: Kilogram...if you have to lift one kilogram, how much effort you need to lift one kilogram weight to one meter.

DR. UFFEN: Per minute?

THE WITNESS: Per minute.

DR. UFFEN: Kilograms per minute?



THE WITNESS: Kilograms per minute.

MR. LASKIN: Q. All right. What's the next category up, as it were?

THE WITNESS: A. Now, next category would be those between thirty and forty percent. Now here...the x-ray maybe look the same, maybe a little worse, but this now is not that relevant.

Now it goes...we have diagnosis, we know he has asbestosis. The next step would be now how he is physically impaired. Now this goes - now how is lung function? His lung function may drop between seventy and eighty percent, okay?

Next thing, when you put on bicycle he may have difficulty reaching six hundred KPM. Now, this would limit him to heavy physical work.

Q. He could or he couldn't do heavy physical work?

A. Well, he would be very tired. He would need rest periods, maybe longer, and we have a scale, a very nice little scale, how much you can perform on different levels of KPM's.

So six hundred...if he is real exhausted by six hundred KPM, we consider that is moderate impairment. By now means, he still can do any average factory work, he still can carry a very comfortable life, everyday activities, but maybe he will have difficulty construction, heavy construction work would be..he would have difficulty doing mining job, lumberjack and all those things. He would have difficulty.

Now, we go a little further. If you reach sixty-seven percent, the man maybe have to stop at three hundred KPM. This would be limited to office work, to any usual...watchman, elevator operator, clerk, so on.

So now, here is the third category. Now, if the





5 A. (cont'd.) man has difficulty walking, undressing, limited to one flight of stairs, he is limited to two city blocks, then you consider him as totally disabled - eighty to a hundred percent.

But there is a schedule established, and we going by those.

Q. I'm sorry. There are...?

10 A. There is schedules, and we have those criteria, and we are sticking to those.

Q. Are they written down? That's what I'm trying to...

A. They are written down, yes. Yes.

Q. Where are they?

15 A. We have in our examining room, hanging on the wall there.

DR. UFFEN: I'm sorry. I don't understand. You said, I think, three hundred KPM, like...

THE WITNESS: It is mentioned here what you can perform.

20 DR. UFFEN: Oh, I would like to see that in the record.

THE WITNESS: I can photostat.

25 MR. LASKIN: Q. You produced to me earlier, and this is what I understand to be a document prepared by the American Medical Association in 1971, called Guides to the Evaluation of Permanent Impairment.

I have just excerpted out a copy of the chapter on the respiratory system, and my friends have some...

30 THE WITNESS: A. Oh, those are numbers, naturally. That is generally what it goes, by age and so on and so on. But we have a much simplified form.

DR. DUPRE: Do I take it, counsel, that this is



DR. DUPRE: (cont'd.) an exhibit?

MR. LASKIN: Well, I want to get...

THE WITNESS: But this is from textbook, is  
5 nothing new.

Q. I suppose I should find...well, does your  
committee utilize the kind of criteria that are set out in this  
guide, is really what I want to find out, Dr. Vingilis?

A. Yes, that's true. We are sticking very  
10 close to that.

Q. You are sticking very close to this?

A. Mmm-hmm.

MR. LASKIN: Well, I think we should, Mr. Chairman,  
introduce it as the next exhibit, and this is fifty-four, Linda  
tells me.

15 EXHIBIT #54: The abovementioned document was  
then produced and marked.

MR. LASKIN: Q. So that if we turn to page  
seventy-five of this excerpt...

20 DR. DUPRE: Incidentally, can I take it that  
the title of the textbook is Guides to the Evaluation of  
Permanent Impairment?

MR. LASKIN: Yes, it is. What happened was, Mr.  
Chairman, I then xeroxed the forward and preface, just so we  
have everything in context.

25 DR. DUPRE: We have the forward, the preface and  
now you are looking at chapter four, the respiratory system?

MR. LASKIN: Correct.

MR. LASKIN: Q. So if we look at table eight  
on page seventy-five, Dr. Vingilis, are those the kinds of criteria  
and judgements that your committee apply?

30 THE WITNESS: A. Yes.

Q. Apart from what may be written in this



Q. (cont'd.) textbook in the part we've called exhibit fifty-four, are there any other schedules...you indicated some more simple schedule which your committee looks at?

A. Well, this is theoretical, but I just show you for a very practical purpose, how much man can perform, as I say, if his vital capacity is eighty-five, he just can be below eighty-five degrees, or if he is fifty-five to seventy percent, or he is less than fifty-five percent. But those for average you will get a little meaning, and how the table show how man can perform if his vital capacity is below fifty-five.

Q. And have you...is that a table that the advisory committee has before it?

A. No, I think...this isn't on our minds just so strictly that...

Q. It's something you know?

A. This is only demonstrating for the visitors, our picture on our wall.

If, for instance, a worker comes to me and wants to talk, and now if I say, if you below fifty-five, you are disabled seventy-five percent. He say, what this mean? Then I show him very nicely.

This is only a lung function test. We are going further. We are going by a stress test, which is much more accurate.

I show him, say well...I did him stress test and he is stopped by six hundred. And I get in my room and I show him, say well, see, you went up to six hundred - let's see what you can perform.

He reads and he is impressed.

Q. What is only lung function test?

A. This is just more like lung function test there.

Q. Exhibit fifty-four?

A. And this one you have.





Q. You are using lung function tests and stress tests?

5 A. Well, lung function test is there. During the stress test, we do lung function. That just goes more, and we are measuring oxygen consumption and CO<sup>2</sup> production and all that. It's much more involved than here.

This is the basics. Our examination is much more comprehensive than here.

10 Q. Am I correct, and please tell me if I'm wrong, but in listening to your evidence, am I correct that in terms of the committee's deliberations that the x-ray is an important tool for diagnosing asbestosis?

A. Correct.

15 Q. But when it comes to assessing percentage impairment, then the x-ray is much less important and it's really the lung function and stress tests that are important?

A. Yes. I think I would say so.

Although there is correlation...

Q. Yes.

20 A. ...but, yes, lung function is more important.

Q. But can you have a situation where you have an x-ray which may show a little fibrosis, but not an awful lot, and yet there might be considerable impairment in terms of lung function performance and stress performance?

25 A. Yes, there been cases. That's what we do stress...stress tests even can anticipate a loss, particularly if you have very strong, well-built, muscular man who is very limited to lung function, still can perform heavy physical work compared with a weakling with poor muscle, although his lung function has fell, but he stops right away.

30 But stress test, when we put the strong-muscled man on stress test, we are realizing where the cutoff starts.



5 A. (cont'd.) He generally does very well to a certain level, and then suddenly drops down. We know that this is abnormal. We know that his physical power pushed him to six hundred, and from there his oxygen consumption, CO<sup>2</sup> production, all that has suddenly dropped down. So we know that although he say, I am the he-man, I still beat the young guys in my company, we know that his lung is damaged.

10 Q. Let me ask you about a couple of specific instances which have been raised before us. What approach does the advisory committee take to percentage impairment in a situation where a particular employee may have an existing condition such as...let's say bronchitis, which is not of itself compensable, and then on top of that gets, for example, asbestosis, which aggravates the condition?

15 A. Now, if there is obvious emphysema where it's very obviously congenital, well it's a little bad luck. He would not get full compensation once he is disabled.

20 If his chronic bronchitis is cigarette related, we do not discriminate this. We just give him full compensation according to our stress test.

Q. And you would not try to single out the impairment that is attributable to asbestosis from the impairment attributable to the bronchitis?

25 A. If there is very obvious, huge emphysematous bulla in his lungs, what is nothing to do with asbestos exposure, so well, naturally, we do not compensate hundred percent because that is not due to asbestos.

But if he has simple, chronic, obstructive lung disease, cigarette-related, we not discriminate for cigarette.

30 Q. You don't discriminate for smoking?

A. No.

Q. Do you take a smoking history?



A. Yes, we take the history, but we recommend impairment regardless.

5 We don't say that he is fifty percent disabled for asbestosis and twenty percent for cigarettes. We don't say so. We say the man is seventy percent disabled, period.

10 Q. Let me give you another type of situation. What approach does the advisory committee take in the case where an employee has an existing disability for asbestosis, say fifty or sixty percent, and that particular person dies not of asbestosis but of some other heart ailment...and I won't even specify a heart ailment for the time being...what approach does the committee take in terms of recommending survivor benefits?

15 A. Well, I think this is strictly medical, legal and compensation, this problem, and we are not dealing with...

Q. You don't deal with that at all?

A. No.

Q. Death cases do not come to you?

20 A. Well, now, this way would come - if, for instance, we assess the man as fifty percent disability and post mortem showed that he was hundred percent...in other words, if we underestimated.

25 But if we think that we underestimated, so then I do receive the lungs from deceased employees, I sent to Professor Ritchie, he do a very comprehensive examination of the lungs, and if he thinks that these lungs been damaged to a certain point, that he was ninety percent to a hundred percent disabled, then we recommend Workmen's Compensation Board readjust the claim and raise to a hundred percent.

Q. Does that happen automatically, without anybody initiating that process?

30 A. This happens automatically when we receive the lungs...if I receive the lungs, and I always refer the lung





5 A. (cont'd.) to Professor Ritchie, our expert pathologist in pneumoconiosis, and he do very, very careful assessment, and then I get report and then advisory board again looks to this report, and if we felt that we underassessed, we send a letter to Compensation Board recommending that assessment be corrected.

Q. What determines whether you get the lung or not?

A. Now, if we don't get the lungs, that's it.

10 Q. But what determines whether you do or don't get it?

A. Well, this I think, I presume, is up to the man or to the family, or to the family doctor, or to the hospital.

Q. So that...

15 DR. UFFEN: Just to...the comments you made a minute ago about this examination procedure. When you have finished with a case, does the advisory committee sit as a committee and review a number of cases and say, this is my recommendation, we have discussed it, and then form a collective opinion? Or do you deal with them as an individual member of this advisory committee?

20 THE WITNESS: Collective opinion. Each case, the films are shown on the board, all records is thrashed through...

DR. UFFEN: Is the Tuesday morning you referred to a little while ago?

25 THE WITNESS: Tuesday, yes, Tuesday morning from eight to twelve is advisory committee, then members meeting and all cases are reviewed.

DR. UFFEN: Do you have such a thing as a quorum, or do you...?

30 THE WITNESS: Well, if there is disagreement, naturally then we try to rationalize, and in case they would be...

DR. UFFEN: Well, how many people have to be there to do business?



THE WITNESS: Oh, yes. At least five.

DR. UFFEN: Five?

5 THE WITNESS: Yes. We insist it would be at least five.

MR. LASKIN: Q. And if there is disagreement, do you put the matter to a vote?

THE WITNESS: A. If disagreement? Well, occasionally we go for voting, yes.

10 Q. But there is only one report that ultimately goes to the Board?

A. Yes, well, that's the...yes, the consensus of the board goes to...

15 Q. But if somebody disagrees with the majority, if somebody disagrees with the majority of the committee, that disagreement is not recorded, I take it?

A. No.

DR. UFFEN: How many cases would you deal with on a Tuesday morning?

20 THE WITNESS: Well, I think there is generally two groups of cases - new cases, they are always more difficult and take much more time; followup for re-examination goes much faster.

If there would be new cases, maybe four or five cases would be only discussed. If they would be followup cases, it could maybe go to ten, fifteen, twenty.

25 MR. LASKIN: Q. I just want to come back to this point about dying from, having a percentage rating for asbestosis and dying from something else. Let's assume there's a sixty percent rating for asbestosis, and the fellow unfortunately dies of a heart attack.

30 Now, would your committee automatically see that case? Would it automatically get referred to you?



5 THE WITNESS: A. No. If Workmen's Compensation Board would ask us to review, we would. Otherwise...sometimes I do for my own interest, I do look myself, but there is not any legal thing. I've always preferred to get the lungs.

10 Q. But has the committee itself, or do you know whether the Board itself, has made any judgement as to what kinds of death cases it's prepared to compensate in situations where the cause of death is not the same as the original compensable illness?

A. Well, I think, no, we do not raise this question, unless we have a question by Compensation Board.

15 Q. For example, we've heard evidence that if you've got asbestosis and you die of right-sided heart failure, corpulmonale, that's compensable.

A. That would be compensable, yes.

20 Q. All right. But what other kinds of situations are compensable? Is a heart attack compensable?

A. No, if there would be no...just plain coronary or left ventricular failure, or congested failure, I guess it would not be compensable.

25 If the man would just die from pneumonia, and he has sixty percent compensation, I feel maybe Compensation Board would be sympathetic and would accept the claim.

But that is...you ask Compensation Board members, I think.

30 Q. You don't get those kinds of cases?

A. No, unless they asked us. If they would ask us to show the case to review board, so then I would represent to the review board and they would decide if they would accept our opinion.

If we are not asked, then we don't.

Q. What about pleural plaque? What's the position of the committee?





5 A. Well, I think pleural plaques by itself is only a sign that the man was exposed to asbestos. By itself it's not disabling, only the sign that the man was exposed.

Now it depends on the size of the plaque. Now, if you have one centimeter plaque all around the chest, this naturally causes another problem - because of fibrothorax, the chest is not expanded properly and this would be compensated.

10 It's very hard to imagine if there would be extensive pleural plaques and lungs not damaged. Generally you see damage to the lungs. They generally have it both. Maybe a little asbestosis pulmonary, would be very extensive pleural changes.

15 Now there is terminology, if you like to hear about. International conference on asbestosis decided that asbestosis terms should be used strictly to the lungs. Pleural changes are not asbestosis. Dr. Selikoff in New York introduced two terminologies. He is using pulmonary asbestosis and pleural asbestosis.

20 To me, this sounds perfect. Only since asbestosis... since this pleural asbestosis would give different meaning to the people if they do not know enough about asbestosis, I presume that's why it's not used.

25 That's why we use pleural changes due to asbestos dust inhalation. Selikoff used two terminologies, but you have to know what this means. Pleural asbestosis doesn't mean disease. Pulmonary asbestosis means disease.

Since asbestosis is used in both terminologies, most people do not know what this means.

30 Q. Pleural asbestosis, I take it, is pleural changes...changes in the pleura?

A. In the pleura.

Q. Which are generally not compensable?



A. Well, I tried to qualify this. Small is not compensable.

5 But, now, only Selikoff uses this. Nobody else in the world used this terminology - pleural asbestosis.

Q. When you say nobody else, I take it the advisory committee doesn't use it?

10 A. Well, not the other, like to say Spencer from Los Angeles, or Gensler from Boston, others, they don't use it.

It's the same international conference what we went to two years ago...including England, they don't use terminology. They strictly agreed to use the word asbestosis involving lungs.

15 Q. Speaking of terminology, can you explain to us this term which apparently your committee or the Board uses, which I haven't seen elsewhere, which is asbestos fiber dust effects?

20 A. Well, this is terminology not that the Compensation Board used, but strictly was introduced by me in that time - 1960, and it been brought because asbestosis never develops overnight. There is black and white, there is the grey area, and for the grey area for me it was very convenient to use this. I never intended that this would be leaked out, I never intended that this would be accepted widely. For some reason it did spread, and for some reason some  
25 books now use this asbestos dust inhalation.

30 That is the stage where is still very vague, that there are nonspecific changed where you cannot tell if it is asbestosis, and that is for us, strictly for clinical use...at that time, at least for me. I used to put a little black tag on the side, or green tag, and next time, next year when I look, I just look more carefully and more compare is there evidence



A. (cont'd.) of asbestosis or is there not.

This is just the so-called early stages, minor abnormalities, which could or maybe not be asbestosis. For any of those familiar with this new ILO code, International Labour Organization code, but is very extensive, then it would be zero slash one. In other words, I think it's not asbestosis, but there is possibility, yes.

Q. Is it compensable at that stage?

A. No, not compensable. This is not diagnosed yet.

Q. What is the purpose of putting that label on it? Do you then follow the person over time?

A. Well, I think...follow the person...that is...okay, three doctors look at the film and one says normal, one says it is normal, but probably is normal. Just is borderline grey case and it is in all occupational diseases that this exists, in silica, asbestos, talc and so on. This is the very grey area, very early stage.

We use the slight effect of asbestos dust inhalation or something, and ILO code, they don't got to by words...they put the number zero slash one.

Because somebody would say...oh, somebody would say suspicious, somebody would say no, still nothing.

Q. What do you do, do you just record the fact and look at the case again next year?

A. No, not next year. Because next year, just you don't see it.

DR. UFFEN: Is there some more to zero slash one? Is there a zero slash one one, or a one slash zero, or...?

THE WITNESS: That would be one slash zero, that you think is early asbestosis, but not necessarily. Then when you get to one slash one, that's when you admit to yourself yes,





A. (cont'd.) I suspect that this is irrevocably asbestosis or silicosis.

DR. UFFEN: Just the three then, zero one...

THE WITNESS: Oh, then you go further. Oh, there's two, two; three, three...

DR. UFFEN: Oh, I see. How high? Is it open ended?

THE WITNESS: The further you go...three slash four, that's the highest.

DR. UFFEN: Three...?

THE WITNESS: Three slash four.

DR. UFFEN: Is the highest.

THE WITNESS: That's far advanced.

DR. UFFEN: Pardon my curiosity. That's a strange set of numbers to stop at. I could understand if it was ten, ten.

THE WITNESS: Really three, three...

DR. UFFEN: Three, three?

THE WITNESS: ...that was the farthest advanced.

In 1980, this new Cincinnati or North America ILO classification say add one more - three slash four. Before used to be up to three.

DR. UFFEN: It's not a precise measure, then? It's a judgement?

THE WITNESS: It is a judgement. Well, this has been designed for statistical purposes, now, because there is always a little disagreement with the doctors. Now, if one doctor codes one, one, another doctor codes two, two, means both disqualified.

But if one doctor codes one slash one, the other codes one slash two, they are both correct because it is in this grey area limits, and they both are correct.

DR. UFFEN: Do you use those indices, if that's the right word to use, in defining or trying to measure impairment?



THE WITNESS: No, they are not directly correlated to impairment.

5 DR. UFFEN: They are not used?

THE WITNESS: Well, I think we use them for the film purpose, yes. We do, because the progress in asbestosis is progressing, yes. In reality it is the further you go, the larger is the number, the more disability. But not hundred percent. You don't go hundred percent with this.

10 DR. UFFEN: There isn't any definite correlation, then, between the definition of impairment and the indices on...

THE WITNESS: It's an x-ray code. That means x-ray code, and is not hundred percent correlation.

15 MR. LASKIN: I just have a few more questions, and they are really general questions about the advisory committee.

Do you...I just want to see if I can follow through the time periods and what you do in a particular case.

20 First of all, are the materials on a particular case sent to the members of the advisory committee before they meet, so they have an opportunity to review it?

THE WITNESS: Q. Oh, no. The appointments been made to examine the man, and when appointments is made, all materials is mailed to us already.

Q. Who makes the appointment to examine the man?

A. The Compensation Board.

25 Q. Okay. And one of your committee goes and conducts the examination?

A. Then the man arrives at our office. We have lab, x-ray equipment...

Q. On Grosvenor?

A. On Grosvenor.

30 Q. Okay.



A. Yes, and then one of the members examines.

Q. All right. And then all of the material is then collected and sent out to the advisory...

A. No. No, what this is..all material collected is kept there. Advisory committee meets at 50 Grosvenor.

Q. Ah, the advisory committee meets at 50 Grosvenor Street?

A. Meets at 50 Grosvenor Street, every Tuesday.

Q. All right.

A. The files is there, everything there.

Q. Will they have seen the files in advance?

A. Generally not, but if you want, you could see.

Q. All right.

A. The files is displayed there.

Q. How long does it take the committee to deal with an average case...and I realize there must be short cases and long cases, but on the average how long does it take to make a recommendation on a particular case?

A. Well, if it's a clear cut case it maybe would be three, four, five minutes. If it's new case, if it's complicated, it could go fifteen, twenty, half an hour.

Very often we still want additional information, very often it's delayed, very often we refer to hospital for further investigation for further tests, for maybe lung biopsy test and so on.

Q. Okay. So would that be the usual situation, where you find you needed further information?

A. Yeah, just if the diagnosis is not clear, yes, that we go further. If the history somewhat do not coincide with our history, we are looking forther to qualify the proper history. If lung function tests, for instance, would be





5 A. (cont'd.) incompatible with the x-ray chart, and we might suspect different, other disease, we may recommend admission to the hospital.

Q. Do you ever consult with the employee's own physician?

A. I think say no.

10 Q. No? Do you ever have before you copies or a copy of the reports done by an employee's own physician? I mean, do you ever have those?

A. Yes, we have those. We have consultant reports, we have hospital discharge forms, we try to get all information that is available.

15 Q. Can you tell us in a general way what reliance, if any, you place upon a worker's own doctor's report? I mean, do you place any weight on it?

A. Yes, very much so.

Q. Do you ever go back to that doctor for more information?

20 A. Yes, if there is some situation that should be clarified, we would.

Q. Does anybody take minutes or notes of the meetings?

A. The doctor who is referring the case, who examined, yes, he is doing.

25 Q. I'm sorry, you may have misunderstood...

A. In other words, if I examined the man, so I'm responsible for the notes, for the opinions, for everything, for recommendations and so on, and then I report.

Q. You are responsible for writing a report?

A. Yes.

30 Q. Okay. But I take it there must be a fair bit of discussion that goes on during..by all the committee members?



A. Mmm-hmm.

Q. Does somebody record that discussion?

5 A. If I think I may forget, I record. If I think I can remember...because I dictate the same day.

Q. Once you do your report, do you then circulate it to the members of the committee for their signature?

A. No, I don't. The doctor who dictates, he signs.

10 But he has to strictly agree with the decision of the advisory...of the Board opinion. It is not permitted...for instance, if I would disagree that there is...if all of the other five decided, I have to hundred percent oblige this decision of the five doctors.

15 Q. Can you give us...I realize this is a general question...but from your experience on the advisory committee can you give us some assessment as to how often the committee members disagree in a particular case? Is it a frequent occurrence that they disagree?

20 A. No, is not frequent. Well, never kept a statistic, but maybe in one case we would be longer discussing than others. Very often the other guy agrees, or he is persuaded, or he accepts the other point of view. Generally it's the point of view, maybe, that is the disagreement.

25 Or, for instance, somebody wants more information or more investigation. If he has good point, maybe he wins and we decide to defer the case and proceed.

It depends how seriously the other members disagree.

Q. But it does happen, not frequently?

A. No, not frequently, but does happen.

30 Q. Are there any particular kinds of issues more than others that cause disagreement? I mean, for example, is it more often the question of percentage rating than diagnosis of asbestosis to start with, that causes disagreement?



5 A. Maybe percentage rating that is most commonly variation, disagree, whether you give twenty or thirty percent. I think it's most likely it would be...now, if there would be serious disagreement like diagnosis, well, we would not complete the case, we would go further and try to find who is right. We would send him...admit him to hospital or do lung biopsy, or suggest lung biopsy.

Q. You try to...

10 A. I think those things, the disagreements, have to be solved to the point, not just a guess.

Q. So in other words, in terms of diagnosis you would try to get enough information so that everybody would agree?

15 A. You have to get proper diagnosis. We just cannot be guessing.

But most disagreement would say, well, you give him twenty-five or thirty percent. Just could be.

20 Q. This may be a difficult question, but let me ask it anyway. From your perception, sitting as a member of the advisory committee, are you able to say whether the views and opinions of one or more of the members appear to carry more weight...put it that way...than other members'? Is there anybody on the committee, is there more than one person on the committee by virtue of their experience and association with the problems, whose opinions might carry more weight than another?

25 A. Well, I think most weight may be carried Professor Ritchie's opinion, because he is a pathologist, he has the lungs and he knows the best in the end. His opinion, naturally, is the most important.

30 Our senior consultants, maybe opinion would be a little respected more than the junior consultant. But there is no particular disagreement.

Q. Is it only medical people who are on your committee?





A. Just medical people.

5 Q. Do they either come from governments, universities or hospitals?

A. Yes.

Q. Are there any that, to your knowledge, are appointed, for example, by unions or employees?

A. Not at present time.

10 DR. UFFEN: How do they get appointed?

THE WITNESS: I don't know.

DR. UFFEN: Well, do you get a letter from somebody saying, would you be a member of the committee?

THE WITNESS: I can just say how I was approached. I was approached if I would be interested.

15 DR. UFFEN: By whom?

THE WITNESS: By Compensation Board.

DR. UFFEN: By the chairman of the Board?

THE WITNESS: No, not the chairman of the Board. I think...I was approached by Dr. Stewart, but I presume he got the agreement of his superiors.

20 DR. UFFEN: But you get a letter of invitation, then, from the Board?

THE WITNESS: Yeah, and then you sign a contract with them, and...

DR. UFFEN: Oh, there is a contract?

25 THE WITNESS: Yes.

MR. LASKIN: Q. A written contract?

THE WITNESS: A. A written contract.

Q. Is it renewed every year?

30 A. Just cancellation one month in advance. If they cancel, you continue to sit one month. Of if I decide I don't want to be a member, I have to inform them one month.

Q. Are you paid for sitting on the committee?



A. Yes.

Q. Can you tell us what it is?

5 A. Well, around a hundred fifty, two hundred dollars a month.

Q. A month? And that includes sitting every Tuesday?

A. Yes.

Q. So it's in the nature of an honorarium?

10 A. Mmm-hmm. But maybe different members, differently. It is strictly confidential, the contract. I don't know. I'm talking about union members.

Q. And there is one other issue I didn't really pursue with you, and I perhaps should have, just on this.

15 You make a recommendation as to a percentage impairment, and I just want to get it clear, you are looking at the question of physical impairment?

A. Correct.

Q. Do you distinguish that term from disability?

A. Yes.

20 Q. What is your understanding of the term disability?

A. I did read American distinction, and disability is decided by sociologists, legal authorities, unions and so on. Medical men supposed to decide impairment.

25 Q. But from your experience on that committee, am I correct in what I think I read, to the effect that the Workmen's Compensation Board, for the purpose of compensating people, accepts the advisory committee's recommendation on percentage in virtually every case? I mean, almost without exception?

30 A. They not communicate it back. I will not know. But I guess they have different ways to modify or adjust,



A. (cont'd.) but I...

Q. You don't know?

A. I not able to talk, no. They not telling us those things.

Q. Are you getting any communication whatsoever from the Board itself as to the manner in which you should be carrying out your functions, or as to what questions you should be asking?

A. No.

Q. None whatsoever?

A. Nothing whatsoever.

Q. Do I take it then that your only liaison with the Board is Dr. Stewart sending you a case and somebody reporting back to Dr. Stewart?

A. Yes.

Q. That's it?

A. That's it.

Q. There is no other communication?

A. Mmm-hmm.

Q. You've got to say no for the record.

A. Well, I think, well, you say no other communication. For instance, maybe we get a request from the family doctor, we recommend, say we want to examine the man in one year time. Now, somebody maybe call Dr. Stewart - the man suddenly get worse. Dr. Stewart asks me whether we would be willing to re-examine the man sooner than one year. I just say well, maybe it's okay, I can see him maybe next month. We get those communications.

Q. Is there ever any community with adjudicators at the Board?

A. No. I not even know them.

Q. All right. Are any members of your committee





Q. (cont'd.) ever asked to testify orally on a particular claim?

A. I never was asked.

DR. DUPRE: Just one question before we break for lunch, Dr. Vingilis. I want to go back to 1971, when as I understand it, you were appointed to the advisory committee on chest diseases.

Now, at that time you were an employee of the Ministry of Health, is that correct?

THE WITNESS: Yes.

DR. DUPRE: You were a classified public servant...

THE WITNESS: Yes.

DR. DUPRE: ...within the Ministry of Health.

THE WITNESS: Mmm-hmm.

DR. DUPRE: What was the title of the position that you held?

THE WITNESS: I think it was supposed to be Physician in Charge of Occupational Chest Disease. I was not the chief at the time. I was running lab and x-ray.

DR. DUPRE: You were within the occupational chest disease service of the Ministry of Health?

THE WITNESS: Mmm-hmm.

DR. DUPRE: Now, did you have to secure the approval of the head of the service before you took up the appointment?

THE WITNESS: I think they approached first my superiors, before they asked me.

DR. DUPRE: I see. Well, now, to what extent were you really asked by your superior to become a member of the ACOCD, as a part of or extension of your duties in the Ministry of Health?

THE WITNESS: They didn't communicate to me at all,



THE WITNESS: (cont'd.) because I knew right away  
that my boss knew I was approached, because they did confirm  
this themselves.

DR. DUPRE: Now, of course at that time, which  
would be 1971, you had had, if I...

THE WITNESS: 1971 or 1972, maybe.

DR. DUPRE: Pardon? 1971 or 1972?

THE WITNESS: 1971 or 1972, yes.

DR. DUPRE: Well, at that time, give or take  
a year, as I understand your background, you would have had  
something like nineteen to twenty years experience...

THE WITNESS: Yes.

DR. DUPRE: ...in the x-ray examination of  
silicosis and asbestosis victims?

THE WITNESS: Yes.

DR. DUPRE: Is it fair to ask you, if you indeed  
can recollect, whether at the time that you were approached your  
own conclusion was that you were being approached because of the  
experience that you had gained over the years as distinct from  
the position...

THE WITNESS: I assumed that was the reason, yes.

DR. DUPRE: Because of the experience?

THE WITNESS: Yes.

DR. DUPRE: It's fair to say, then, that  
membership on the ACODC, if a physician involved is a public  
servant, in normally in no way directly linked to the position  
he holds within the government? It is, instead, linked to his  
professional expertise as it has been judged by those who  
invited him, the individual?

THE WITNESS: Well, ...

DR. DUPRE: Well, can I put it to you this way.  
You've had some successors in positions that you have. Has



DR. DUPRE: (cont'd.) any of them, to your  
knowledge, every come on to the ACOCD by virtue of having  
succeeded you in a particular position, either when you were  
at the Ministry of Health or when you were with, subsequently,  
the Ministry of Labour?

THE WITNESS: No, we been three physicians in  
my level. For some reason I was picked, but I don't know why  
they picked me. They just communicated me.

DR. DUPRE: Thank you.

Shall we...Dr. Uffen?

DR. UFFEN: Could I ask one just quick...just to  
clarify...remember when I asked about a quorum and how many  
people were there. I'm curious to know, medical doctors can't  
always be there on Tuesday morning, something else may happen  
like another demand. Does anybody keep track of who is  
actually present? Is there any kind of an attendance?

THE WITNESS: No, I think this way...if I had  
controversial cases, so I make sure that those cases present  
when all quorum is there, or all senior members is there. In  
case some senior members is not there, or what you consider  
heavy guys not there, we try to process simple cases or  
noncontroversial cases. Anything what is more difficult to  
decide, we leave those for the day when we know that everyone  
is there.

DR. UFFEN: I understand that, but does anybody  
keep a record...

THE WITNESS: No, I don't think they keep a  
record.

DR. UFFEN: There would be no way of going back  
and finding out whether a particular member was a good attender  
or a poor attender or...?

THE WITNESS: No, we don't keep these records.



DR. UFFEN: Let me put it another way: Are there some people who attend regularly and faithfully and make a large contribution, but some who come when they can?

THE WITNESS: Well, I think some members is always there, some members maybe do skip some, particularly those in private practice. But I think everyone tries to attend.

DR. UFFEN: It depends on the individual's abilities and other things?

THE WITNESS: Other commitments, yes.

DR. DUPRE: But it may depend very much on the extent to which the individual is a member of the public service, or whether he is in private practice?

THE WITNESS: Maybe, because in public service they are right in the building.

DR. DUPRE: Right.

THE WITNESS: I presume they are probably everytime available. Those in private practice maybe would be skipping occasionally.

DR. UFFEN: But I also read or understood from what you said, 'and the degree of interest in the cases to be discussed'.

THE WITNESS: Yes. For instance, if I had a very controversial case and I see that maybe two of our senior members is not there, I would not discuss this case that particular Tuesday. I would leave for the next Tuesday.

DR. DUPRE: One connected question, Dr. Vingilis. From 1972 on, when you were on the ACOCD, and of course were also a member of the public service, were you ever told explicitly or implicitly given the understanding that your membership on the ACOCD was looked upon by your superior as part of your duties as a public servant?

THE WITNESS: Yes.





5 DR. DUPRE: I see. So that the assignment in that sense, because you were a public servant, even though it was on a committee of the WCB, was basically viewed as part of your job content as a classified public servant...

THE WITNESS: That is correct.

DR. DUPRE: ...first in the Ministry of Health, then in the Ministry of Labour.

10 THE WITNESS: Yes, now, only this thing now. If I wrote the report as a member of the advisory committee, this report I could not...the Ministry would not me defend writing this report...

DR. DUPRE: Right.

15 THE WITNESS: ...because this report was written as the advisory committee member, and any complain to the minister, for instance, would be irrelevant.

DR. DUPRE: I see. But nonetheless, the time that you devoted...

THE WITNESS: Yes, they permitted me, yes.

20 DR. DUPRE: ...was looked as part and parcel of your function?

THE WITNESS: Yes, as part of the...they give me permission to work a half a day for the advisory council.

MR. LASKIN: Q. And your supervisor, the person to whom you reported within the Ministry in the last three years of your employment, was Dr. Pelmier?

25 THE WITNESS: Well, in the first two, three years. Yeah, I guess Pelmier.

Q. Pelmier? And before that?

A. Before that was Dr. Roebuck, and Dr. Cowle.

MR. LASKIN: Thank you, Mr. Chairman.

30 DR. DUPRE: Shall we then rise until two-twenty?

THE INQUIRY RECESSED

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THE INQUIRY RESUMED

DR. DUPRE: May we reconvene?

Counsel, do you have any further questions?

MR. LASKIN: I did have a few more, Mr. Chairman, but perhaps I'll reserve them and in the unlikely event my friends don't cover the areas, I'll come back to them at the end.

DR. DUPRE: Who wishes to cross-examine first?

MR. LEDERER: At the moment I don't have any questions, but in any event since I am here on behalf of the Province of Ontario, and since Dr. Vingilis has been called in his capacity as an employee of that government, it seems best that I reserve any questions I have until after my friends have completed.

DR. DUPRE: Thank you, counsel.

Mr. Starkman?

MR. STARKMAN: Yes, sir.

DR. DUPRE: If you please, sir.

CROSS-EXAMINATION BY MR. STARKMAN

Q. Dr. Vingilis, when you were reciting what your qualifications were, I became a little confused. As I understand it, you would be the equivalent of a family practitioner in the Province of Ontario? You don't have a specialist's accreditation? Would that be correct?

A. At the present time, yes. But at that time I was...I did six years training in chest disease and I was employed as a chest physician.

Could I tell more? To qualify myself, at that time I had to go two more years training, it was to Hungary, and I did go and I was hired by Ministry of Health in this capacity.

Q. This is in 19...?

A. In 1953, February.



Q. So then I'm correct, you do not have a specialist's accreditation?

5 A. No, I don't, no.

Q. Now, the...you say you were hired in 1953. What was the job called at that time, that you were hired to do?

A. Was clinician. I have to read the films, mostly the films of occupational chest disease, and interview people.

10 Q. All right. Then I take it you had perhaps a number of positions, but in 1971 you became the physician in charge of the occupational chest disease section...

A. Mmm-hmm.

15 Q. ...of the Ministry of Labour? Would that be correct?

A. Ministry of Health at that time.

Q. Oh, in 1971.

A. Ministry of Health at that time.

Q. And does that job...did that position have a job description?

20 A. Yes, I presume it would. This meant I was in charge of two other doctors, secretaries, technicians and so on.

Q. But that position had a job description?

A. Yeah, it had one, yes.

Q. Do you have it that you could provide it to the Commission?

25 A. Yeah, I think could be in Health Ministry files. I don't have it myself, but it would be in the files.

Q. Then I take it that this chest disease section became part of the Ministry of Labour in 1978, would that be correct?

30 A. Around that time.

Q. Was the...did your job continue in the same...





A. Yes.

Q. ...manner as it did before?

A. Yes.

Q. So you are in charge of the chest disease section. How many people work in the chest disease section?

A. About twenty-three, twenty-five, twenty-seven. It varies from time to time.

Q. And does that include clerks, secretaries?

A. Yes.

Q. And who else is there? There's yourself as the head, and are there other doctors on staff?

A. Two doctors, sometimes three.

Q. Two doctors, sometimes three. Who else would be in that section?

A. Well, two more doctors. Like, Dr. Walker, Dr. Budlowski, Dr. Roose. I guess Dawson, more recent years.

Q. Okay. I'm talking about within a recent time.

A. Yes.

Q. In the years just before you left that position.

A. Yes.

Q. So other than the doctors, who else would be there to make up twenty-two or three...

A. Well, besides the doctors, oh, well, was organizer...what you call...Mr. Counselor, used to organize the clinics. There was about ten x-ray technicians, sometimes ten, eight, twelve, depends on demand.

I think there was four secretaries, there was two or three lung function technicians.

That's about it.

Q. Okay.

A. There was a filing clerk, two filing clerks at one time.



Q. Okay. Now, I'm not clear as to what the actual purpose and function of the chest disease section is. What does it actually do? You have three doctors, some technicians, some people who do laboratory work, etc., but what is the purpose of that section?

A. We are the mobile x-ray units.

Q. Yes.

A. And those units travel from plant to plant and x-ray people, and later on doing lung function tests.

Q. That's the purpose of the unit?

A. The purpose of the unit.

Q. Is there any documents or policy statements which set out what the purpose is? Is there anything in writing which addresses itself to this?

A. Whatever this Silicosis Act passed in 1952, that all people exposed to silica test should be examined by a government-appointed, by minister-appointed doctors. There is big Silicosis Act, if you referring...

Q. Okay.

A. ...19, I think 1952 Silicosis Act and Regulations.

Q. So that's what prompted the setting up of this...

A. This...well, everything was existing for twenty years before, but just for the legal base or legal grounds for existence.

Q. All right. But are you aware of any ministry policy documents which talk about the function of the unit? What it's supposed to do, what guidelines it is supposed to operate under?

A. It was a big regulation - thirty page - and there was a guideline through the regulations.

Q. The regulations under that Act?



A. Under the Act.

Q. But are you aware of anything other than the regulation? Any policy documents?

A. No. I guess we acted according to the regulations.

Q. Who did you report to?

A. I reported to the director at that time.

Q. Well, let's just deal with it in recent years. What position would the person hold who you reported to?

A. I think he was director of occupational medicine. This includes toxicology...I think at that time was two branches - chest disease and toxicology, and one group was toxicology, dealing with toxic materials, and we dealt with chest disease.

Later on that was split and divided. Now I think there is many groups, plus laboratory there.

Q. Well, let's just deal with it in terms of the month before you retired. Who did you report to?

A. Oh, it would be to occupational health...no, is Dr. Pelmier, and she is director at present time, occupational health service, occupational branch in Ministry of Labour.

Q. So you reported to Dr. Pelmier?

A. Yes.

Q. Who was the director of the occupational health services?

A. Health branch.

Q. Health branch of the Ministry of Labour?

A. Ministry of Labour.

Q. Now, as I understand it, the primary job you were doing was organizing mobile x-ray units to go out around to various plants and take chest x-rays? Would that be right?

A. Yes.



Q. How would you determine which plant to go to?

A. Well, I think first, anyone who uses silica dust, it was on the regulations. Also, it's under the Act.

But we extended to any toxic material what we thought could be injurious to the worker's health. So we went in isocyanides, we x-rayed expeople who used talc, hot metal, beryllium.

Q. Are there lists of these substances as you have identified them?

A. A very long list, yes. And then we surveyed, for instance, for five or ten years. We found out that we didn't find anything unusual, then very often you drop those things what are considered irrelevant.

Q. So those lists are available?

A. Oh, yes. All files are available.

Q. Now, dealing with asbestos. You determine that you should go and take x-rays of those employees or persons who were working with asbestos. Would that be correct?

A. Mmm-hmm. Asbestos is one of the items what we be concerned.

Q. All right. Now, as I understand it, asbestos was treated somewhat differently than the other toxic substances because you went to asbestos places once a year as opposed to once every eighteen months?

A. Correct.

Q. Now, that decision, would that be your decision alone, or would that be made by your supervisor? Who would make that type of decision?

I'm trying to find out how the decision-making process works within your section.

A. We'll have to go to 1952. I was one of the members of the...who made decisions, but I was maybe not THE member.





5 A. (cont'd.) There was Dr. Matthew, I presume, Dr. Sutherland, I presume, and Dr. Riddell, of course all dead now, and there was a decision made and we proceeded that way.

Q. So those people were all doctors employed within that section as well?

A. Yes.

Q. So it was made internally by the medical staff?

10 A. Dr. Riddell, this was my direct superior who hired me.

Q. Now, once you have made that type of decision, how do you get a list of what plants and places to go to, to know that...how do you know what places are working with asbestos or asbestos products?

15 A. We had a so-called industrial health counsellor, by the name of Dave Moore. His job was to locate the plants and go in the plant, check whether there is hazard, and if there was a hazard, then he would talk to the plant management and they decided whether our program should be introduced or not.

20 If they felt that there was a hazard, they introduced our program. We used to go and x-ray.

I directly did not participate in searching for the plants or introducing program. I was doing strictly medical work.

25 Q. But this is one...you mean there would be one person for the entire province, who would go and see whether there was substances which needed...which might be in need of supervision?

A. Yeah, he was the man...yeah, he was the man.

Q. Just this one person?

A. Yeah.

30 Now, there was some communication with other branches of the ministry. There was a branch of industrial



5 A. (cont'd.) health and safety, there was a branch of mining. They used to communicate...inspectors, for instance, to inspect the plant and thinks that something maybe is suspicious, they would pass a message to Mr. Moore, and then he would investigate.

10 Q. I take it from what you are saying that this person went to the plant and said I think you have a problem, you should make use of our mobile x-ray unit, and if management said no, we don't want you here, that would be the end of the matter? He could not go on there because he would have no legal basis for insisting that management, or on the other side, the workers, co-operate in that type of program?

15 A. What the silica concerned, there was no problem, that was the law.

Q. Let's just deal with asbestos.

A. Okay. Now, asbestos, we tried to persuade people, and I cannot recall a single case where the plant would refuse to co-operate.

20 Q. So when the decision was made that you should go there, how would people be notified of the date that you were going to actually arrive?

25 A. Oh, Mr. Moore would contact us, our organizer, he would send a letter to the plant and say, we will be able to arrive certain hour, certain day in your plant. And then we going to x-ray some...we used to arrive, mobile unit, plant knew in advance and the people come from the plant and we x-ray them.

Q. Would you be working off a master list of employees so you would know who came and who did not come?

30 A. Yes, yes. We used to send them cards and then...green card, yellow card for every employee...and then we had the card and then we go in the plant and we know exactly



A. (cont'd.) who is in the plant.

5 Q. So the people who didn't manage to make it on the day or days that you were there, you would just...nothing would be done about that?

A. No. We used to travel around the province every six months. Like, we picked up those we missed last time, or x-rayed the new ones who been hired in the interval. So we used to travel around the province every six months picking new  
10 employees, but every eighteen months in silica exposure, for every year in asbestos exposure, we would x-ray whole plant.

There used to be one survey and two followups what used to come.

Q. To try to get the people who...

15 A. Those they missed, or hired new in the interval.

Q. Now, as I understand it, the x-rays would be taken and as I understand there was some sort of card where the x-ray results were noted. Is that correct?

A. Yes, that's correct. Like, in those days the card, on one side was the name and they used to...like, in  
20 all x-ray you put a number on the x-ray film and you used to write the number on the card, so this x-ray is identified with the card.

On the reverse side, the doctor used to write report.

25 Q. But I understood there was a certain type of designation which indicated the extent, or the health of the persons lungs, with various categories and classifications on the card?

A. No, not really. There was the code, on the other side, the code of the reading for our statistical purpose.

30 Q. Okay.

A. And the code was just like pleurisy, seventeen;





A. (cont'd.) abnormal heart, twenty-three, and so on.

5 The doctor, when he reads the film, on the reverse side he puts the code. So our statistician or clerk who summarized and do summary at the end of the year, so he know what that means.

Q. What sort of coding system was it?

10 A. Well, again, this can be carbon copy. There is...silicosis was called...oh, dust disease was coded from one to six, and then all other disease has different numbers. Like, active pleurisy, eighteen; old pleurisy, seventeen; heart, twenty-three, and so on. There was all this...pneumonia, seventeen G, and...

15 Q. But dealing with asbestos and asbestos dust, I take it that there would be a coding system between one to six?

A. Well, one to six. Now, one two, three, that is mean nondisease, nonspecific. That's a normal variation.

20 Disease started by four. Four was the grey area. If a doctor thought that this was a little abnormal, they used to put the code four, number four.

25 Then the next time he reads the films and he looks twice, or maybe if he said four...in asbestos was no problem, they was taking large film anyway...but used to be in other exposures would take miniature films in those days, tiny little seventy millimeter...you take seventy millimeter film and you not so sure. You put four, and then either you call the guy back, or maybe next six months you take the large film to make sure what you see.

Q. Yes, but the system itself, is that an internal system to your...

30 A. That's internal. That's our system.

Q. So it would work, I guess, is that the x-rays



Q. (cont'd.) would be taken, they would be brought back to Grosvenor Street to develop, and then you would examine them?

A. Mmm-hmm.

Q. And when you examined them, you would also, I take it, if it was a second or third time that an x-ray had been taken, you would look back at the x-rays from previous years to re-examine those?

A. Yeah. Was put together, yes.

Q. So if this was a third x-ray, when you looked at the third one, you would then look at the first and second ones at the same time?

A. Yes. If is strictly normal, you maybe don't bother. If it's a little abnormal, you fully can compare, yes.

Q. And you would also have the person's card there?

A. You have person's card.

Q. And on that card would be the indication as to whether it was a one, two, three, four, five or six?

A. Yes.

Q. And those notations would be primarily your notations?

A. Yes.

Q. Because you had been doing most of the reading?

A. Yes.

Q. So when you looked at someone's card, let's say you put down a two?

A. That's normal chest.

Q. All right. But two is different than one?

A. Well, yes and no. One, two that would be just a normal chest. This would vary from density from undevelopment, a little change, just so on. One or two, there



A. (cont'd.) is so minor difference it is still considered normal chest. No disease.

5 Q. I understand that. But this system which is internal, is it reduced to writing to indicate what the differences are between one and two, two and three, three and four? Some guidelines to people who read these?

A. Maybe it would be a little variation, but the one, two would be no variation.

10 Q. Is it reduced to writing?

A. Well, one and two would not be reduced to writing. Three, yes. I think three I would, if I put the code three, I would make comments about it on the other side.

15 Q. No, I'm not asking you whether you made comments. What I'm saying is.... you have a system coding one through six, for noting what your impressions were of these x-rays.

A. Mmm-hmm.

Q. Now, you didn't do all of the readings, I take it?

20 A. No, not, no.

Q. All right. So someone else who was doing the readings would also be using this coding system?

A. Yes.

25 Q. Now, was there anything reduced to writing which would help someone interpret whether or not it ought to be a one or two, three or four, whatever? Is there some explanation of what these numbers mean? A guide to somebody who is trying to use them and understand them?

30 A. No, this was not for the other people. Just writing codes was strictly for ourself. Now, mainly the coding was designed one, two, three, four when we take miniature films, you are reading on the road. Because miniature films, we being



5 A. (cnt'd.) x-raying and interpreting at the plant. Doctor used to go into Hamilton, units go into Hamilton. They are x-raying ten, twelve thousand people there, and doctor used to go in Hamilton...

Q. All right.

A. ...doctor go in Hamilton and screen miniature films. And he puts a little code in there.

10 Q. I understand all that. I'm questioning just on the...

A. Okay. Now, I'm glad to say where the code is now. Doctor load the film, is a little increased markings. Now, he's curious, is something new or old. Look on other side, was marked three before, he knows that it was three  
15 before, he don't need to worry. Otherwise, he call the man back, take another large film.

So one, two, three, forget about. That's no meaning. That is not a disease, but is just couple wrinkles in your face or couple lines here.

20 Now, when we go to four...well, I cannot...if you don't understand this problem, I can't help...if the doctor commits himself to four, when he commits himself certain degree, but is possible could be occupational disease. He puts four, and then he gets large film.

25 When he gets large film, he gets home and then he takes another film in six months and then he decides what to do with the man.

Q. Where did this system come from?

30 A. I found the system when I was hired. The system was before me, when I start work in 1952. This modified system from South Africa miners. There was primitive codes used at that time in South Africa mines.





A. (cont'd.) Later on, there was ILO code, which was more sophisticated, more detailed and was good for statistical purposes.

Our code is strictly diagnostic code. Is not fit for studies. Is not fit for research. Is diagnostic code for our own internal use.

Q. So there is no literature on the code as you use it?

A. You can find, if you look 1920's and 1925, in South Africa mine history, you will find similar codes, very similar codes.

Q. That's the code that you based this code on?

A. This was acquired by Dr. Riddell, and I carried it on.

Q. But other than those writings, what I was initially asking, is there anything that you had or the ministry had reduced to writing which would help various people who were reading these x-rays arrive at roughly the same results, in terms of the coding system? Even for internal purposes, to make the internal coding consistent, is there a written guideline to people who read these x-rays?

A. I think if you want the interpretation you have to read the wording, you need the report. Code is irrelevant, because code five could be from mild asbestosis to advanced asbestosis, still would be five. It would not help.

Q. So there is nothing in writing?

A. The five, this means that the man has asbestosis, period. Don't say how bad it is.

If you want how bad it is, read the report.

Q. I understand what you are telling me, but I asked you whether it was reduced in writing so someone else looking at this code and trying to interpret it would be able



Q. (cont'd.) to arrive at the same results that you are telling us today.

5 A. Okay. They have to get ILO code. If they do ILO code, you know how to interpret ILO code, there is much more detail. To interpret ILO code, you need a good training, otherwise you would not interpret anything.

10 Q. So do I understand it then that the coding system that is one to six, if I could read and understand the ILO code, then I would understand the type of coding system that is being used by chest disease section?

A. No, chest disease section use simple code, much simplified. ILO code is complicated code and is good for research purposes.

15 This code is good for our clerks, our technicians, to do the annual summary. If it's five, he knows there is silicosis. If I ask him how many silicotics, how many asbestotics, he counts fives and he tells us ten fives, means is five asbestosis this year.

20 That is not any more there. Don't try to read in this code any more.

Q. Do you still use this code?

A. They still use this code, yes. Is very practical code used for everyday use, for statistical purposes. Not for research purposes, for statistical.

25 Q. Yes.

A. Now, if our statistician wants to do statistical study, he ask me to recode. I take...I read the films and I code ILO code. This ILO code is very detailed, very precise, very time consuming and is very fit for statistical research purposes.

30 DR. DUPRE: On this diagnostic code you used, what did the number six mean?



THE WITNESS: Six, that mean is conglomeration, big shadows. Five just means more nodules.

5 DR. DUPRE: Five, as I think you stipulated, would mean that the diagnostician's opinion was that this was an asbestosis case?

THE WITNESS: Yes. Now, again...

DR. DUPRE: And six would be the complications, put it this way?

10 THE WITNESS: No, those code one to five is not really suitable for asbestosis. Is really suitable for silicosis. We use just other side.

MR. STARKMAN: Q. Dr. Vingilis, my problem is... let me explain to you my problem...we are talking about asbestosis, you are using the code for asbestosis and I'm asking  
15 you if you continue to use it, how is someone going to understand it? Like, for example, you did most of the reading, as you told us.

THE WITNESS: A. Mmm-hmmm.

Q. Now you are no longer there. Someone else  
20 is doing the readings and they are continuing to use this code. How will they know, when they look at an x-ray, on a code which is very...which has its own parameters, whether or not the x-ray is a three, a four or a five, even for your own internal purposes, without some guidelines?

A. Yes. I had to use different...I used to  
25 use the tags eventually, put the blue and red to mark the file. Because what the problem is, asbestosis is is not the lungs. If I had a tiny little asbestosis, say three code, for the lungs, and I put seventeen for pleural plaques, and the man has crackles, I know he has asbestosis. And I put brown or red tag to tell our clerk that this is asbestosis.

30 Q. I don't want to really beat this to death,





5 Q. (cont'd.) but I know you know what you are doing. I'm asking you how other people who are using the same code with no written guidelines, how they would know what you were doing?

A. Well, I would have difficulty to explain there. He has to pull out film, he has to turn the cards around and read the report, and end of the report there is summary and no tag...this is asbestosis or something.

10 DR. UFFEN: Mr. Commissioner, I have drawn the conclusion that was passed on by word of mouth

MR. STARKMAN: Well, we don't know that. I am not even sure if that's so, but...

DR. UFFEN: And only one mouth.

15 I don't often do this, but I think you've made your point.

MR. STARKMAN: Yes, I will move on.

MR. STARKMAN: Q. But without dealing with that, the problem we have just been discussing, what use is made of those numbers once you have done that sort of analysis? What's  
20 the purpose in doing that, coding between one and six?

THE WITNESS: A. Well, to help because...this is for statistical purposes, for our clerk. You could summarize and do annual report.

Q. What happens to those statistics, do they  
25 go into the annual report?

A. They go to our director and he knows what is going on in Ontario.

Q. And anyone else who reads it...well, we can get copies of those reports and read them and see what they say.

30 A. Yes. Sure. At end of the year, I prepared reports of every case, and this is all in ministry files. You



A. (cont'd.) can find. At the end of year was very precise, thirty page report of our activities.

5 Q. Now, I take it that these reports, these chest x-rays that come in and were examined by yourself. I just want to get it straight as to what happens to the results.

Let's assume that the result shows that someone has asbestosis...on your reading of it. Now, what is the procedure then? That report is sent..one is sent to the company?

10 A. Yes. The company, plant doctor.

Q. Plant doctor or nurse? Or do you think of them as the same?

A. We always address to the plant doctor.

Q. All right.

15 A. If there was no plant doctor, next copy goes to the family doctor.

Q. Yes. And one goes to the WCB?

A. In the years since the rehabilitation started, about 1970, 1971, we sent one copy. Not before.

20 Q. Since 1971, one goes to the plant doctor, one goes to the family physician and one goes to the...

A. Compensation Board.

Q. Compensation Board.

A. Not Compensation Board. To Dr. Stewart.

Q. Dr. Stewart.

25 If the family physician is not known, then no copy goes out? That's all.

A. If there would be, I would try to find a family doctor.

Q. Right. But if you can't find one, then one doesn't go out?

30 A. The plant doctor's duty was to inform him.

Q. And in cases where there is no plant doctor,



Q. (cont'd.) then it goes...then who is the correspondence addressed to?

5 A. If it's asbestosis, we finally phone the wife or company, ask to contact the man, and I used to get family doctor.

Or if he didn't had, we asked him to get a family doctor and let us know.

10 Q. But I asked you if there is no medical doctor or nurse at the place of business, who is the report addressed to?

15 A. We don't address report. Our contact man just phones the plant manager, he would get the man on telephone, our contact man would phone the man and say who is your doctor. If he says I don't know, I say who is your wife's doctor. If I don't have any one, get one. and then we will send to you.

Q. Okay.

Now, if someone's x-ray showed a deteriorating lung condition, you would want to examine those every year, is that the generally accepted time frame, one year intervals?

20 A. That vary from months, maybe, to years. If I say it's urgent case, I would pretty well say, well, see right away family doctor, admit in hospital and do further investigation.

25 If I decide the man is stable, I say I see in one year. If I think the man is progressed sooner than I anticipated, or I suspected, I say see me in six months.

It is varied from time to time, from case to case.

Q. To see you?

A. Not me, family doctor.

30 Q. See your family doctor. You write them a letter suggesting that they go to see their family doctor?

A. Yes. Yes.



Q. Do you write their family doctor suggesting the family doctor tell the person to see them?

A. Yes, I write them. That's correct.

Q. Now, what about in the construction industry. What sort of control or monitoring would you have done in the construction industry over the last ten years?

A. Well, here we deal with union leaders. They been very co-operative, very sympathetic. They try to do their best, and because of the work pattern we generally get Saturday or Sunday, or sometimes Friday night, go to union hall and construction workers would arrive there, we would x-ray them, and try to get family doctor numbers from there, because there was no company doctor. And that's how we deal.

Sometimes if I didn't have a family doctor, I used to write a letter to the man...not medical report, only stating that abnormal shadows been found in your chest, please give us the name and address of your family physician so we can send you a report.

Very often we got very quick report, because the man was naturally scared.

Q. Did this system indicate that you were able to follow up on employees from year to year?

A. Then that would be sent to the family doctor, and the family doctor would follow.

Q. Yes, but that's what I was asking you, that it seems very...well, were you able to follow an individual employee through, let's say a decade? And be able to meet and x-ray that person or examine them every year, through this process that you have described?

A. Yes. Because I probably saw him next year again, if he was there, because we followed every year. Ladders we tried to do every year.





Q. Who? I'm sorry, I didn't hear that?

A. The insulators, we try to x-ray every year, the same way.

Q. And iron workers?

A. Iron workers? No, those was eighteen months.

Q. So if you go to the ministry files and look for the name of let's say an individual iron worker or boiler maker, you would be able to see that they had been examined every eighteen months or approximately, there?

A. Eighteen, yes.

Q. So the records are complete?

A. Yes.

Q. Essentially, on that type of examination?

A. Yeah. You only have to know the name of the company, so you find the man, because our files is filed companywise. If you say you want to find Mr. Smith, would be difficult. I would ask you what company he worked. If you say Defasco, I get Defasco in two minutes.

Q. I realize that, but you know that most of the construction in this province is done by very...done in relation to very small employers, so you might ask, I mean there are probably or ten thousands of employers.

A. No, just ask what union he belong. Those files been, records been filed in the union. The Union 95 and Union 64, whatever the numbers for there. They been filed with the union files.

Q. I don't understand. What's filed with the union, the medical records are filed with the union?

A. The union..you mentioned the name, and number was ninety-five...all members they belonged to this union, was filed under this name.

Q. I understand that. But maybe...I'm trying to



5 Q. (cont'd.) differentiate between fixed-site work places like Johns-Manville or Raybestos Manhattan, where they have one place where they carry on business and usually one union local which is representing those people, as opposed to insulators or iron workers or boiler makers who may work for twenty-five or fifty different employers during the course of a year.

10 A. No, now again you are mixing. Insulators belong to two unions only.

Q. Yes.

A. Now, boiler makers and pipe fitters, they belong to the company. They not journeymen. They are company men. Pipe fitter is hired by the company, he works as a pipe fitter, and his records is at this company's files.

15 Q. That's in your experience? Pipe fitters, iron workers, boiler makers, work for one company, one employer, steady employment?

A. Most of the time, yes.

20 Q. That's what you have discovered in your years working for the ministry?

A. That's correct, yes.

Q. So therefore it's only necessary to go to those employers and...

A. Find your records.

Q. And find them?

25 A. That's correct.

Q. Well, I'm going to suggest to you that that's not so, that iron workers and boiler makers really do work...

A. What you mean, iron workers?

30 Q. What I'm suggesting to you is, that people involved in the construction industry, they work for a variety of different employers during the course of a year, and that seems to be the pattern in Ontario - to have a variety of



Q. (cont'd.) different employers during the course of a year. It's those people that I want to talk about, not the people that work for one...

A. You mean construction workers.

Q. Construction workers.

A. Yeah. Construction iron worker is not exposed. He wouldn't have an x-ray.

Q. Okay. So if you are involved in construction, even if they were working with asbestos products, there was no attempt to x-ray them?

A. Yes, you may right.

Q. I didn't really understand that answer.

A. Well, unless it is insulators, yes, that's correct.

DR. DUPRE: May I see if I understand just where your questioning may or may not have gotten here, counsel?

As I understand it, very simply, when you are examining workers, whatever their particular function, who are in fixed-place asbestos firms, you identified them through records that were supplied to you by the employer?

THE WITNESS: Mmm-hmm.

DR. DUPRE: On such occasions as you were examining them, any workers who were in nonfixed-place industry, construction of one kind or another, the records, such as they were, were provided to you by the union?

THE WITNESS: By asbestos unions.

But now, if there was construction worker or pipe fitter work on his own, those we missed, most likely.

MR. STARKMAN: Q. So as I understand it, if people were involved in construction, there was no effort made to provide them with any services from the chest disease section? Would that be accurate? Construction workers, people involved in building buildings?





THE WITNESS: A. Maybe you are right, yeah. I would say not efforts be made, but was very difficult to get them.

5 Q. Well, you say maybe I'm right. I'm asking the question. You are the one who is in charge of the section. Were efforts made to examine construction workers, or weren't they?

A. We tried, but they was very difficult to get and we didn't get results.

10 But they not been organized, how you x-ray them, how you suggest that...I have no idea how we could x-ray them.

Q. You thought that the logistical problems of carrying out the job were insurmountable?

A. Yeah, you may say is correct.

15 Q. And the same would apply, I guess, would apply to those involved in demolition work as well?

A. That is correct.

Q. Was there ever any studies or efforts made, any studies made of the scope or the magnitude of these problems? Of reaching the construction and demolition workers?

20 A. I think our organizer, he did efforts, but at that time was practically impossible. Even he had difficulty with organized ladders...great difficulty to x-ray them regularly.

Q. All right. What was this organizers name?

A. Dave Moore.

Q. Dave Moore. Is he still there?

25 A. No, he's dead about five or ten years...seven, eight years ago.

Q. He's been dead for seven or eight years?

A. Now Jake Benner is in his place.

Q. Jake Burner?

30 A. Benner, B E N N E R.

Q. Benner.

So, I mean, what I'm asking, was there ever a



5 Q. (cont'd.) decision made to study this problem, or was there ever a decision made to have a committee look into it or anything along those lines?

A. Well, I was not in a position...as a physician I wasn't in the position to make those decisions or influence decisions.

Q. You were head of the section?

A. Medical section.

10 Q. All right. Who was in a position to make those decisions that we are talking about now?

A. Engineering.

Q. That was engineering. That's the engineering branch of the Ministry of Labour?

A. Yes.

Q. Who is the head of that section?

15 A. His assistant is Cumming.....it's McNair, McNair.

Q. So I take it that you, as the head of the medical branch, would have quite a bit...quite extensive dealings with Mr. McNair, particularly concerning this problem that we are talking about?

20 A. Yes. There was quite a discussion. Now, there's nothing new than what I heard, the job is not directly my field, I was medical man and my job was x-ray and diagnose the people, diagnose disease or chest disease, but I heard discussions going that they tried to do the best - demolitions and construction sites. But Mr. McNair and Mr. Cummings could give you better information regarding this.

25 Q. And was Hugh Nelson involved in that as well?

A. Maybe Hugh Nelson, Rajhans and so on, those engineers. This is engineering problem.

30 Q. Those people are on the engineering side?



A. Yes, yes.

Q. So they make the...is it the engineering side that makes the decision as to which plants to go to and...

A. Oh, yes. Because if there is no dust counts, we don't go. Have to be dust. Have to be exposure. Had the exposure identified under microscope by laboratory, by dust samplings and so on.

Q. So engineering does that and then they just tell you they would like you to send a mobile unit to this place and this place and this place?

A. Yes. There is a hazard, and you go and survey. That's my job.

Now, all those previous questions what you questioned me, that is strictly not mine.

Q. I'm glad we finally found that out...

A. I tried to...

Q. ...because I was proceeding on the assumption that it was within your jurisdiction.

A. No, I am medical department. I am the doctor.

Q. Do you have any thoughts as to how it would be possible to monitor the health of construction workers, as a doctor? It's one of the issues the Commission is dealing with.

A. I would be glad to go and x-ray and examine them if I would be directed, if engineers or laboratory or dust technicians found the dust in there.

DR. DUPRE: Your answer is that if dust was identified in their working environment, then under such circumstances, as a medical man, you would think that x-rays would be appropriate?

THE WITNESS: Yes, yes. I would send our...what you call it...organizer, and he goes there, he delineates areas who is in exposure, who is not exposure, and then we go and x-ray.



DR. DUPRE: This is on construction sites?

THE WITNESS: Construction or plants. The same plants...like, not all plants been exposure. For instance, Stelco and Defasco has twenty, thirty, forty thousand employees and x-raying only five, ten, twelve thousand.

DR. DUPRE: But on construction sites, in your experience, there was never anything conveyed to you by the engineering division that identified dust so that then you could go in and provide this sort ...

THE WITNESS: No. I couldn't help.

DR. DUPRE: Okay.

MR. STARKMAN: Q. Now, I would like to talk now about the advisory committee, and when you were being asked about this this morning, I think you said that the number of people on the advisory committee fluctuates. I guess with the fluctuation, would it be fair to say that fluctuations are like five, six, seven people?

THE WITNESS: A. Yes.

Q. Are you aware of any guidelines as to how many people are on the committee, or how they are appointed? You just know about your appointment?

A. That's true.

Q. You don't know about how anyone else was appointed?

A. No.

Q. What is the tenure of your appointment? You were appointed in 1971, and is that just continued until either you or the WCB gives one month notice and then it's terminated?

A. That's correct.

Q. We heard you are paid a stipend for doing this, and that, I take it, is on a WCB cheque? You are paid by the Workmen's Compensation Board?

A. Mmm-hmm.





5 Q. As head of the occupational chest disease section, is the person who was head of the chest disease section before you, was that person on the advisory committee?

What I'm really asking is, if you were head of the occupational disease section does it seem like you are also on the advisory committee, as far as you can tell?

10 A. No, I think...I mean my predecessor, he was on the advisory committee.

Q. Yes, and your successor, is he on the advisory committee?

A. Yes, he is.

15 Q. Now, who else is on the advisory committee, as of this time?

A. Dr. Grey from University of Toronto, Dr. Muir from University of McMaster, Professor Ritchie is a consultant, as a matter of fact, at University of Toronto...

Q. Just a minute. He's not on the advisory committee?

20 A. He is consultant advisory committee.

Q. Well, is he on it or is he off it?

A. He is on, yes.

Q. He is on, but he...?

A. As the title of consultant.

25 Q. How does that differentiate him from the other people on the advisory committee?

A. You have to ask Compensation Board.

Q. As far as you know, that's just his title?

A. I know he is there, yes.

30 Q. He is there, and he's got consultant before his name?

A. Yes, yes.

Q. All right. So there's Dr. Ritchie and...?



A. That's right. Dr. Ritchie, yes.

There is now Dr. Rorabeck (unintelligible),  
Dr. Mehle, is Ministry of Health.

Q. Mehle?

A. Mehle.

Q. Mmm-hmm.

A. And Dr. Roos, Ministry of Labour.

Q. Ruth?

A. Roos, R O O S.

Q. Oh, Roos, yes.

A. And Dr. Budlowski, is for the Ministry of  
Labour, but different branch. He is from toxicology.

Q. So...

A. And Vingilis, myself. How many is that?

Q. Well, I'll read you through the list again,  
that you've mentioned.

I take it...you are still on the advisory committee?

A. I'm still, yes.

Q. So there's yourself, Dr. Grey, Dr. Muir, Dr.  
Ritchie, Dr. Rorabeck, Dr. Mehle..

A. Mehle, M E H L E, I think.

Q. Okay. Dr. Roos...

A. Roos.

Q. ...and Dr. Budlowski.

A. Budlowski.

Q. So there's eight people on the advisory  
committee?

A. Yes, now is eight.

Q. Is Dr. Wolf on the advisory committee?

A. No.

Q. Now, eight are there and five, I believe  
you said, make a quorum?



5 A. Well, Professor Ritchie, he participates only on invitation if we discussing pathology reports, special pathology reports. He regularly do not participate....Professor Ritchie.

Q. So when you are counting the five, is it five of seven or five of eight?

A. Five of seven.

10 Q. So if five aren't there on a Tuesday morning, then no decisions are made.

Now, as I understand it, I am informed that this is an advisory...this is an advisory group which advises the Workmen's Compensation Board, would that be correct?

A. Yes.

15 Q. I understand that the letters that are written are written on Ministry of Labour stationery, and when you write to, let's say the Workmen's Compensation Board, that letter goes out on Ministry of Labour stationery?

20 A. Now it's labour, before it was health, because only one stationery we have. Theoretically maybe we should get no-headline stationery, but this is correct, yes. We using stationery because the secretary, one of my secretaries types, is headline as Ministry of either Health previously, now Labour.

25 DR DUPRE: Basically is it fair to say that your office in the Ministry of Labour provides a secretarial service for the committee and sends out its letters?

THE WITNESS: Yes, because this is a part-time job. It's a part-time job, she is not full-time job. Now, I guess, maybe going to be changed. Is part-time job.

MR. STARKMAN: Q. You are talking about your secretary has a part-time job, or...?

30 THE WITNESS: A. The secretary.

Q. Your secretary works there part-time?

A. She types my reports or anybody reports, yes.





5 Q. Well, I guess what I'm really getting at, is there significance in the fact that it goes out on Ontario Ministry of Labour stationery, or is that just coincidental?

A. Would you ask legal advice? I have no idea about legal things.

If it's illegal, it should be changed.

10 Q. I wasn't asking that. You are suggesting it's just coincidental because you happen to be in the Ministry of Labour and your secretary is a part-time secretary and has the stationery available. That's just...

A. That's the way. But if it's illegal, could be changed. I not against. If you think it's illegal, well, can prepare the motion and...

15 Q. I don't think it's illegal, I think...

A. Why you question?

Q. Well, I think it's somewhat deceptive, in that people receiving those letters have the impression that they are coming from the Ontario Ministry of Labour.

20 A. Those reports should go down into Dr. Stewart, nobody else.

Q. Well, I have letters that are sent out that come to people's possession, which are written on that letterhead, so I'm just saying I think it's deceptive to people who receive them.

25 A. But on the bottom signature is, what on bottom say?

Q. The bottom says, on letters that you might send, say J.J. Vingilis, M.D. advisory committee on occupational chest disease.

A. This is it, clarifies the situation.

30 Q. Now, the committee, as you described the seven people who are on the advisory committee, is there...in the time



Q. (cont'd.) that you've been on there is there... has there been much changeover in the committee? Has it remained relatively constant, as to members?

A. Some died, some died and some new been appointed.

Q. I won't get into how long the various people have been in. Do you meet regularly with the WCB to discuss your role and function?

A. No.

Q. Someone being appointed to the advisory committee, how would they understand what their role and function was?

A. I think Dr. Stewart interviews before he hires.

Q. Yes, and it's at that time that he would explain to them, is what you are saying?

A. I presume. I don't know.

Q. There is no written guideline?

A. I did not receive.

Q. All right. When the WCB is working out various standards, like the various guidelines for asbestos claims, do they...are you involved in that process?

A. No.

Q. They don't ask you for any advice on that?

A. No.

DR. DUPRE: May I just follow up, counsel, and clarify something in my mind?

In your own case, Dr. Vingilis, never mind any of the others, in your own case when you were appointed a member of the AC OCD, who briefed you about the kind of job you were taking on? Was it Dr. Stewart?

THE WITNESS: Was Stewart informed me I been hired, and then the chairman at that time, when that was, of the committee...



DR. DUPRE: The chairman of the committee?

THE WITNESS: He did, and the first few months you are observer, you are watching how things goings and that way you learn it.

DR. DUPRE: Who was the chairman when you became..

THE WITNESS: Dr. Cowle.

DR. DUPRE: Who is the chairman now?

THE WITNESS: Dr. Rorabeck.

DR. DUPRE: In your case, basically, Dr. Stewart informed you of the general nature of the position?

THE WITNESS: Yes.

DR. DUPRE: But such briefing as you received, in terms of what you were being asked to do, was given to you by the chairman?

THE WITNESS: Yeah, by chairman, and by sitting in few committees, you are learning.

DR. DUPRE: Right.

MR. STARKMAN: Q. You said Dr. Rorabeck was your chairman?

THE WITNESS: A. He is chairman at the present time.

Q. And at one time he was your supervisor, is that correct?

A. He was director before he been transferred to labour. When in Ministry of Health, he was...

Q. He was your supervisor?

A. Director, yes.

Q. Director. Do you ever have any...does the advisory committee ever meet with the Workmen's Compensation Board to discuss any problems, matters in common between...other than initial hiring...the picture I have is there is an initial hiring and then people go to the committee, and the committee just carries on, and is there ever any discussions between the



Q. (cont'd.) WCB and the committee concerning the committee's work and its function?

A. Maybe in minor...in the policy discussions or individual case discussions?

Q. Are there ever any policy discussions?

A. No.

Q. No policy. Now, on an individual case discussion, are there individual case discussions?

A. Sometimes there could be, yes.

Q. That would be between the examining doctor on the advisory committee and Dr. Stewart, would that be...?

A. Well, examining them, naturally, and this examining doctor would discuss with the committee.

Q. The examining doctor would, of course, discuss the claim with the committee?

A. The committee, yes.

Q. All right. Well, we will come to that. But on an individual case would the examining doctor discuss the case with someone at the WCB?

A. Generally, no.

Q. I take it you view the role of the advisory committee as strictly a medical one?

A. Strictly.

Q. So in other words, they do an examination and they send the result of their examination to the WCB, and the WCB then makes whatever decisions it makes?

A. That's correct.

Q. You are not advised of those decisions, and never inquire into them?

A. No.

Q. Dealing with the examination process, is it one member of the advisory committee which is in attendance at





Q. (cont'd.) Grosvenor Street on a particular day?

A. Yes.

Q. So each one is assigned a day or an afternoon...

A. Correct.

Q. ...to be in attendance?

A. Correct.

Q. Then people come and they are examined?

A. Yes.

Q. And these people are referred by the WCB?

A. New cases, yes. Followup, we have our system.

We do follow...

Q. Okay, let's deal with a new case. New cases are referred? Do they send you a note telling you that a case has been referred?

A. Yes.

Q. You describe the type of examination that someone who has a claim, is concerned about their having asbestosis, goes through, and one thing you mentioned was this stress test, I guess I was just thinking about lifting up one kilogram...

A. Stress test, yes.

Q. The stress test, now what is that stress test?

Is it riding a bicycle?

A. Yes.

Q. It's riding, like a stationary bicycle?

A. Well, specially-designed bicycle.

Q. Who manufactures this bicycle?

A. Now we got just from Germany the most expensive, pay seven thousand dollars. But you can get cheaper. We have a good one because it has to be stationary, it has to be strong, it has to be good, well calibrated.

Q. Does everyone who comes in with an asbestosis or alleged asbestosis problem take this stress test?



A. No, by far. No, is other things.

5 Q. How do you determine which of the claimants, if I can put it that way, would have the stress test?

A. We get in our mind which should not have the test. For instance, electrocardiogram show abnormal heart, man has a recent coronary, we do not stress those cases.

10 Well, those cases are stressed in hospitals, cardiac stress test is done. Our main purpose is not cardiac fitness, but lung fitness, so we try to avoid...we don't want somebody suffer cardiac arrest, although we have all the resuscitation equipment in our place. We have the fibrillators, we have oxygen, we have intubation, we have everything, but we don't want any chances...

15 Q. All right. But if someone doesn't have a heart problem and they are claiming about a lung problem...

A. Lung problem, okay.

Q. ...like an asbestosis...

A. Asbestosis, yeah.

Q. ...problem, are they all given a stress test?

20 A. Yeah, he would be stressed. Now if he refuse, naturally, he has the right to refuse, and refusing naturally would not reflect, but most people interested. If I explain what it is, most guy interested, some are even enthusiastic.

Q. So everyone is given one then?

25 A. Yeah. Now if person has, for instance, bad arthritis in his knee or in his hip, more likely stress would be limited, again.

Q. Now, during the course of your examination do you take blood tests?

30 A. No, we do not invasive tests. This would be third stage stress test. We just go to the second test.

We have ear oximeter. This attached to the lobe,



A. (cont'd.) and we checking his oxygen saturation in the blood. I think it's very accurate.

Q. I don't...

A. The third...blood test is done for the third stage of stress test. You have to get in artery blood and continuously monitor the blood. That is third stage. We don't do those things.

Q. Why don't you do those?

A. First, it's invasion. Second, it's a danger, and as a matter of fact I wouldn't want to do myself if I would be patient.

Q. Does it have...is it valid medically for assisting in the diagnosis of asbestosis?

A. I think yes, in certain cases there is indications for those tests.

But this would be more for medical reason, for instance for medical disease, excluding something. We not stressing there. If we go that far, we give benefit of doubt to the man.

I think second stage stress test is perfectly satisfactory for our purposes.

Q. Do you do sputum tests?

A. Yes. That's irrelevant at present time, since TB is eliminated, but earlier days we did very carefully, and for the miners or for tuberculosis, for miners we do still sputum test.

Q. Sputum tests won't help in the diagnosis of asbestosis?

A. No.

Q. Now, I guess after you...the examining doctor has made or has completed the examination, he then takes the results of his tests, his observations and the x-rays to the advisory committee meeting?





A. Yes.

Q. There they discuss it and they agree, at least the majority agree, on a recommendation?

A. Mmm-hmm.

Q. Or if I can put it...on what the diagnosis is.

A. Mmm-hmm.

Q. One thing that concerned me when I hear you describe it was, if there is a split...let's say you have a case that goes to a vote and it's even, say, three to two, and the examining physician is in the minority one way or the other, you then said that they, nevertheless, write the letter over their signature. Does that appear to you to be a medical, ethical problem in that a doctor who is sending out over his signature an opinion which isn't really his opinion, and arrived at by another process?

A. Doctor who examines the man, naturally his opinion is very important, because he directly examined the man. But I guess there is no other solution what you can do.

Sometimes we postpone...if is split that close, like three to two, very often we postpone and re-examine in six months.

Q. And if it's five to one, but the one dissenting opinion...

A. Oh, five to one, well, I guess that is clear decision. The guy has to oblige with five decisions, because if the five thinks that way, I don't know, I will think, well, I might be wrong, if those other five think differently.

Q. You don't see any ethical problem there?

A. No, I don't see anything wrong.

Q. All right. And you don't think that if there is a split in opinion that the Board who you are reporting to should be notified that there was a dissenting opinion, let me put it that way, one way or the other?



A. I don't think we want to contaminate the Board with those things.

Q. I don't understand that.

A. I think the Board...we make the decision to the Board, and if we felt that the decision is not very accurate, we recommend to follow up examination in, say, six months time.

Q. Dr. Vingilis, are you making decisions, or are you making diagnoses?

A. Well, first is diagnosis.

Q. Yes.

A. Then next is disability.

Q. Yes.

A. The third is percentage of disability.

Q. Yes. Let me just read to you from a report from the advisory committee to the Workmen's Compensation Board, which I assume is perhaps close to what a common report would be.

It says...it seems to be a form at the top.

It says:

"The findings and recommendations of the advisory committee on occupational chest disease regarding the above claim are as follows".

Then there's these comments:

"No radiographic progression seen.

Pulmonary function tests are within normal limits.

They have not deteriorated since the last examination.

Signs of asbestos dust inhalation, but no significant asbestosis.

Suspect angina. Re-examine in two years.

We recommend that the claim not be allowed."

A. Correct.

Q. Would that be, not a typical one, but an example of one?

A. Is typical one. Now you should read now x-ray



A. (cont'd.) report, a little higher.

Q. It doesn't seem to be on mine. It just says, "film", and there's Toronto and then a number.

A. That would be...this is the followup report, most likely, not the original. But there should be x-ray reports.

Now, this man, my interpretation, he had pleural plaques, pleural thickening, but not pulmonary asbestosis.

Q. It's not your letter anyway.

A. Yes, but this most likely was the case - the man had pleural thickening, pleural...if you use Selikoff's expression...pleural asbestosis, but not pulmonary asbestosis, his lung function was normal and he was not disabled. That's why the claim was not recommended, not accepted at this time.

Q. Okay. But a letter like this, which says, "Signs of asbestos dust inhalation..."

A. That just means pleural fibrosis, pleural thickening. That is the expression what they use.

Q. All right. I just want to read you this sentence again.

It says: "Signs of asbestos dust inhalation, but no significant asbestosis".

A. Yes, correct.

Q. No significant asbestosis, means there's asbestosis but it's not significant. Is that the meaning?

A. No significant evidence of asbestosis should be maybe put there.

Q. Okay. Now, would that report, "signs of asbestos dust inhalation", or whatever term you put to it today, would that then go to this person's family doctor? That would be the procedure...

A. No.

Q. ...because it shows some deterioration?



A. No, because we leave this prerogative to Compensation Board communicate with. Our mandate is to Compensation Board.

Q. I thought you said that one copy goes to the family, the company...

A. Not this one.

Q. Not the ones who are referred from the advisory...not the ones who are...

A. Not advisory committee, because the same like life insurance.

Q. All right. Only the ones from the x-ray, etc.?

A. Oh, this is ministry. This is not a ministry board. The bottom say, member of advisory committee. Don't confuse with ministry employee.

Q. So when someone comes to the advisory committee and there is a report made, that report only goes to the Workmen's Compensation Board?

A. Correct.

Q. Nothing goes to the family doctor, nothing goes to the...

A. Well, maybe I should add...now, if I see the cancer there, or I see a large heart there, I do both - I report to Compensation Board hoping they will report, or sometimes I do phone the doctor myself and say, I examined your patient for Compensation Board, I think he has a large heart and congestive failure, would you please examine him. I do that.

Q. All right. So what you are saying is, when you see a very serious problem you phone, and if the problem is less severe, then you may or may not phone?

A. If is strictly industrial, that's Compensation Board. If there is medical component...for instance I see electrocardiogram, maybe doctor is not aware he has recent coronary.





5 Q. So in doing your examination, you separate between what you are referring to as the industrial component and the medical component?

A. Yes, that's what I do. Because if I see this man has maybe coronary, maybe you ask him and he's not aware, naturally his doctor is not aware, I feel my duty to inform his doctor that that man has a coronary, he is not to...

10 Q. I understand that. But if you see he has asbestosis, you don't have that same duty because it's a WCB...

A. That is Compensation Board deal.

Q. So once the Compensation Board is involved in this manner, you just let them handle it?

15 A. That's correct. Because they will not...maybe they do not agree with our decision. They are not bound to our decision and I cannot tell anything. Maybe they decide that the man is hundred percent disabled, not fifty or twenty.

Q. Now, at the bottom line of this it says:

"We recommend that the claim not be allowed".

20 Is it normal for the advisory committee to make recommendations on that?

A. Yes.

Q. All right. So you do more than just the diagnosis? You do a diagnosis and a recommendation based on that diagnosis?

25 A. Yeah. We find that there is no disability and we recommend that the claim...but again, this recommendation, it's not binding to them, they may allow.

Q. I understand that.

30 Have you ever done...we had some brief discussion about the fatal claims...have there been any studies done, followup studies, on people who have made claims and have died?

What I'm suggesting is, if you had a hundred



5 Q. (cont'd.) people that have made a claim and they died, you could examine, you could have examined their lungs and compared the findings of the advisory committee against what was actually found upon death?

A. Yeah. I have collection of material. Is very interesting, is very good, I hope the guy who succeeded me takes time and studies...there is very interesting material available.

10 But as I say, there is...

Q. What type of interesting material are you referring to?

A. Yeah. I hope one day he is going to study and maybe publish.

15 Q. Well, what type of material is it? I mean, what will it disclose?

A. Well, I think you are comparing...we always learning in medicine from pathology reports. How the man looked when he was alive, how he looked on x-ray, how he looked on lung function, and then Professor Ritchie gives you very nice result how it really was. We collected those.

20 But amazingly, my just observation that very rarely we be wrong. If we say the man was hundred percent disabled, Professor Ritchie agreed that that was advanced.

If we say there is no asbestosis, very often he finds that there was either very little or none.

25 But this study should be done one day. There is material accumulating now, because at present time there is not much materials accumulating. We do not have that many dust cases, and for ten or twenty, thirty cases, you cannot make any good statistical study.

30 I think in maybe another ten, fifteen years, there will be enough material to do good retrospective study.



Q. Well, is there material available on this now?

I take it...

A. It's available, but there is still small amount. Statistically, most likely, would be not significant.

Q. Now, I take it what you are saying is that when an asbestosis claimant dies, there is no generally-accepted procedure for performing an autopsy?

A. No.

Q. So an autopsy may or may not be performed...

A. Correct.

Q. ...depending on the individual circumstances?

A. Mmm-hmm.

Q. So you only have a chance to look at the ones where autopsies are performed?

A. Yes.

Q. And there's some evidence, albeit small numbers, which might show...where you might be able to compare what the autopsy report is against what the findings or the recommendations of the advisory committee are?

A. I always compare it, and I do correct all the materials and we have some so-called pathology days, Tuesdays, and I show all my members. This is teaching process.

Miners, they are much better co-operatings. We get much more lungs from the miners than from asbestos workers, for some reason.

Q. Why would that be, do you think?

A. Well, I don't know why...that they better educated...but from the mining communities I get very, many lungs, thoracic organs, in Toronto, and they are very useful for those purposes.

But, well, for teaching, for statistical...

Q. When you are talking about this process, are





Q. (cont'd.) you talking about people who died and then bequeathed their lungs for scientific research?

5 A. Yes, that's correct. No, no. Well, very simple now, in mining communities is accepted if the miner dies and the pathologist do autopsy, and he sends us thoracic organs. He even don't bother dissecting. He just nicely puts in formalin, puts in ice bag and address to me, send to us.

Q. Would this be...in your opinion would this be...

10 A. It's very useful.

Q. This would be a useful purpose...

A. Very, very useful.

Q. A useful thing to have done even in...

A. I wish this would be done the same with asbestos workers.

15 MR. STARKMAN: I think those are my questions.

DR. DUPRE: Thank you, counsel.

Miss Jolley.

CROSS-EXAMINATION BY MISS JOLLEY

20 Q. I would like to go back to the organizer identifying asbestos workers for your medical surveillance system, and my understanding is at Johns-Manville, all of the workers at Johns-Manville were in fact...did participate in your...take a place like Bendix, down in Windsor...

A. Yes, I know.

25 Q. Would the organizer go in and identify different areas in Bendix where workers would not..where they would think that workers were not being exposed?

A. Yes.

30 Q. So that those workers who worked in those areas where the organizer decided were not participating in your medical surveillance?

A. Now, if I am correct, I think he did two or



A. (cont'd.) three surveys, both plants, and then eventually...

5 Q. Who did those? That would be the engineering branch?

A. No, no. I think engineers find that there was some question of dust in one other plant, and I think we went there and we x-rayed on two or three occasions, both plants.

10 Later on, it was brought to our attention that one plant is not exposed at all...

Q. Now?

A. No, at that...well, five, six years ago.

15 Then we felt a little conscious unnecessarily x-raying people because of unnecessary radiation, so I think in the past year or two we x-rayed only one plant there where we thought there was some exposure.

Q. But jobs were essentially being defined by your organizer as nonexposed jobs?

A. Yes. He used to go to the plant and check, because we don't want to x-ray the people not exposed, you know.

20 Q. No, I understand that.

A. But you have two sides of the story - one, you radiate unnecessary people. Next thing, you neglecting maybe what is there. I think organizers been trained people, those are university graduated, and they went carefully through the plant. If he was in doubt, he used to send engineers to do the dust counting and then he decided which group of people should be x-rayed and which group maybe should not be x-rayed.

25 But again, this depends on engineering.

30 Q. I think the concern there is down the line when people are defined as being in nonasbestos exposure, and then they come forward for compensation for asbestosis or for other asbestos-related cancers. Do those two pieces of information



Q. (cont'd.) come together?

A. Yes, it did come together. I heard about the story.

Well, I heard only what is used for the newspaper stories, because cancers are dealt directly by Compensation Board and they do not consult us.

But whether that particular person had a lung cancer, did he work in exposure or not, I am not sure.

Q. Can I come back to the codes, and I'm not going to beat this to death again, the South African codes, you mentioned at the very beginning when you were talking about the use of medical surveillance, this whole system that you set up, at the very beginning this morning you said one of the purposes is for long-term research and that you wanted to publish...

A. Oh, well, this I was mentioning...I had to recode, read the films all over, for about four hundred asbestos-exposed people, and do ILO coding. So that statisticians could do statistical studies, because our code is not suitable for statistical studies.

Q. Right. So there are ILO codes on the x-rays...

A. Oh, yes. Yes.

Q. ...if people want to do...

A. I know this code and I pass exams, and...

Q. No, our impression you left us with is that if they, you know, if we are going to do research we don't have any useful code.

A. No, if we need, we recode it, everything.

Q. The other thing that you have just said to Mr. Starkman that you were concerned about, invasive testing?

A. Yes.

Q. Okay. I'm concerned because you kept mentioning this morning that people were having lung biopsies, and one of the





5 Q. (cont'd.) real concerns is that the workers at Johns-Manville, I know, received letters from Dr. Stewart indicating that the Workmen's Compensation Board did not require lung biopsies for the diagnosis of asbestosis.

A. Correct.

Q. But why are you continually mentioning lung biopsies?

10 A. No, they are only recommended if there is good doubt that there is some other, curable disease possibly present, and just because the person worked in asbestos or in silica, could you automatically accept this as such and not overlook serious disease. We recommend only not for compensation purpose at all, but for the diagnostic purpose. There is some  
15 tendency to believe if I work in foundry, I going to get silicosis. If my shadows looks like silicosis, it is silicosis.

But any foundry man can get any disease, the same like the guy who works in the ivory tower. So if I think that the shadows are not compatible with occupational chest disease, if they occur too suddenly, they appear just overnight, most  
20 likely nonoccupational. I recommend to go into the hospital, maybe, do the lung biopsy and get diagnosis.

But not for compensation purposes, just...

Q. Who do you recommend this to?

A. The family doctor.

25 Q. The family doctor?

A. Oh, yes.

Q. Do you also indicate the hazard involved?

30 A. Well, during my twenty years I saw the cases with silicosis-like shadows appeared in two weeks. To me was clearly not silicosis, and finally I find out the man never was been silicosis, he worked in Stelco where is twenty thousand employees, he was miles away from the foundry.





A. (cont'd.) Just because the doctor is ask where you work, is Stelco, oh, that's classical silicosis.

5 There are those cases we recommend biopsies, but we never recommend biopsies for compensation purpose. If I am convinced that this is silicosis or asbestosis, that is good enough.

10 But we don't want to make wrong or misdiagnose curable disease, you know what I mean? Just assume that this is silicosis or asbestosis, and there is not. Other disease could be diagnosed by biopsy and man could be cured. Otherwise, you don't know.

We have responsibility not only Compensation Board, but when we examine a lung disease, you want to get the diagnosis, proper diagnosis.

15 Compensation is secondary.

Q. With your hat on with the advisory committee now, say we'll deal with you specifically, and you see a patient, say, Monday afternoon is your day at the clinic and you see a patient on Monday afternoon. When would that case be discussed on the Tuesday morning sessions?

20 A. Would be not likely this Tuesday. It would be a week Tuesday.

Q. A week Tuesday?

A. Mmm-hmm.

25 Q. Then a decision is made, say, that you have five members there so you are able to go ahead and a decision is made that you all agree that this person should or should not, or has asbestosis and has ten percent, twenty percent or whatever. What happens then?

30 A. I write report and they take report and the secretary types, and...

Q. How long does that take?



A. Oh, maybe another week or three days.

Q. We've been told that there is often six month  
5 delays from the time that the patient is seen at Grosvenor  
Street and the time that Dr. Stewart...

A. Yes, is correct.

Q. Why is that?

A. There is the rare case where we have to  
10 get material from other hospitals, where we have to get the  
biopsy report, where very often we have to contact the man to  
get permissions...always very rare cases where we have to  
collect material from different stories. This could be involved  
about five percent cases...to do research, double-check exposure,  
send our counsellor to find out whether the company he worked  
15 he really worked, and that he worked there with a real exposure.  
Because company...

Q. Your counsellor, I'm sorry?

A. Counsellor, the organizer.

Now, quite often the company denies, we never  
20 had asbestos in our company, we never had silica. They have  
to look in the records. Is true. Then some...but a rare,  
small number, about five percent of cases they do go two,  
three months. I think six is over-exaggeration, but two,  
three months, yes. But only five percent of cases.

Normally, one month. Now, say one month, first  
25 thing you have to send the letter to the man, we give him date,  
date is not suitable to him, he sends the letter - I cannot arrive,  
takes about two weeks already.

But we try to deal as soon as possible with this,  
as quickly as possible.

Q. The other thing that really rather concerned  
30 me this morning was your whole discussion about the ethics of  
information going between doctors, etc. Are you familiar with



Q. (cont'd.) the Krever Commission's findings?

A. Yes, to some degree. Well, if this change, you have to change.

Q. I mean, do you think that...I mean I was very concerned you don't want to alarm the patient by telling them that they have a disease. I think that's a very paternalistic approach to...

A. No, my expression was, I don't want to step behind the family doctor. You know what's happen there? He goes to his family doctor and tells, you know, I have such-and-such a disease, you never told me.

That is very often what happens, and we, in specialty, we try to avoid this confrontation. We feed the doctor, the family doctor, and then he confronts the patient. He knows his emotional state, he knows emotional condition and so on. He can approach much nicer than I, seeing for the very first time the man...I tell him just blunt to the face, sir, you have asbestosis or you have cancer.

Q. But the company doctor...at least the family physician, has not sent this man to you. I mean...

A. No, you know, but the family physician is responsible for the man's health, so he has to know everything what...

Q. But don't you think that workers have a right to know?

A. Yes, workers have to know, but I like that this information would be received from his family physician.

But if this ethics is going to be changed, well I agree with...

Q. Do you know if there's discussions about the ethics being changed as a result of the Krever Commission?

A. Yeah. Well, they will change too.





Q. Has there been any discussion, while you were still at Grosvenor Street, about actually...

A. Yeah, it was.

Q. Do you know if there is going to be a policy change?

A. No, you have to ask the present doctor who is doing my job.

Q. The other statement you made this morning which I thought was a little bit strange was that you looked at, during your surveillance of workers, you looked to see whether there was more occupational disease than you would expect.

Is the philosophy in terms of medical surveillance that you do expect to get occupational diseases?

A. Why we do surveying?

Q. What's that?

A. Why we do surveying? Biological tests is always the most accurate test. Dust counts, everything is good, but that's why we going and we checking and we seeing whether this dust counts is good or bad, or satisfactory or not satisfactory. That's why we do surveying.

Q. Okay. My concern is that you have done surveying at Johns-Manville since when?

A. Well, I did personally since 1953, but I...

Q. 1953?

A. ...saw some records done earlier, even as long as 1948.

Q. Right. So from the time it opened, essentially?

A. Yes.

Q. There were occasional visits from the engineering branch of the Ministry of Health as well, presumably...

A. I presume there was, yes.

Q. I mean, since 1976, we were able to see some



Q. (cont'd.) of the results. We weren't able to get them before.

Now, you say one of the benefits of this medical surveillance system is to...that employees' health are somehow protected, ultimately?

A. Mmm-hmm.

Q. How did your information...I mean, you see people coming up in 1964, the first asbestosis case...

A. Yes.

Q. How did you put that information together and who did it go to and what happened then?

A. Well, medical information went to the medical personnel, but they raise hell with engineers - should go and see what's going on.

Q. Right. And what went on?

A. Well, I think that is from engineer's side. I cannot tell much, but...

Q. But you kept seeing...then you kept seeing more and more and more cases in Johns-Manville?

A. I was getting madder and madder and madder.

Q. And the engineers were, presumably, going occasionally, and nothing was happening?

A. Ask engineers, please. I can't talk for them.

DR. DUPRE: I just want to ask at this point, Dr. Vingilis, when you were communicating to the group that you are calling the engineers, what was the name of the branch, please?

THE WITNESS: I think was industrial health branch. Industrial health branch?

MR. LASKIN: Yes, industrial health and safety.

DR. DUPRE: It would have been the industrial health and safety...



MISS JOLLEY: No. Industrial health engineering branch.

5 DR. DUPRE: You were communicating to the director of the branch?

THE WITNESS: No, I was not...there is in government policy, you have to communicate at your level. I think I was communicating with one of the...would be maybe what engineer is the same level as I was.

10 I think was...guess would be Hugh Nelson or Rahjans.

DR. DUPRE: So you would have been communicating either with Mr. Nelson or Mr. Rahjans?

THE WITNESS: Yes.

15 DR. UFFEN: Could you clarify something for me, though? I believe we were told in testimony earlier on that the people who went to the plants were primarily industrial hygienists, that the ones that were qualified to determine the health effects of dust were industrial hygienists.

You bring in an engineer in to set up the instruments and make measurements.

20 Do you make a distinction between engineers and industrial hygienists, or are they all in the same...

THE WITNESS: I think they all the same. I'm not exactly sure what the difference is between those two.

25 DR. UFFEN: Would you regard an industrial hygienist as part of the health profession?

THE WITNESS: Yeah. I think a hygienist is a little higher than an engineer. Hygienists might be a chemist plus engineer, and he takes some special course in this kind of...

30 DR. UFFEN: So it might be these industrial hygienists that you are referring to?

THE WITNESS: I think they call themselves hygienists. It mean a little higher than engineer, a little higher



THE WITNESS: (cont'd.) than chemist. They had a little extra title or extra training.

MISS JOLLEY: Q. I guess, then, that you are not the one to ask, but I just don't understand why that information was all being amassed and no one was doing anything. But you are not the one to ask that.

At the Reeves Mine outside Timmins, you were surveying those people?

THE WITNESS: A. It was not the mine, but at that time I had one foot in the mines a little, too. I am aware of.

Q. Right, right. Do you know how many people went through that mining experience at Reeves?

A. A small number, I presume.

Q. There was quite a large turnover.

A. That the mine...well...

Q. We are not talking about the mine that is operating now, if it is.

A. I know.

Q. We are talking about the Johns-Manville mine.

A. No, I don't think...I just remember Reeves Mine.

Q. That's it. Yes.

A. The Reeves Mine?

Q. Yes, the Reeves Mine.

A. I just know was closed. This mine was closed?

Q. Yes.

A. And that's the way...yes, what we did...what my job was there, to try to trace exminers and examine them.

Q. Right, but were you surveying those miners when they were actually mining asbestos up there?

A. No, there was a mining group, those doctors





A. (cont'd.) that live close by.

Q. They were not part of your group?

A. Was not exactly part of my group, yeah.

There was a mining...mines, there was a...

Q. I know the Minister of Natural Resources...

A. ...mines they have own...

Q. ...was responsible for the mining operation.

A. Yeah, they had mining stations, the mining station doctors.

Q. But they didn't operate a medical chest service?

A. They had the, yes, the mining stations had a medical chest survey.

Q. Oh.

A. Whether they x-rayed this Reeves Mine or not, I don't know, but mines been x-rayed by mining stations.

We did only Bancroft Mines here, uranium, around here.

Q. So you weren't regularly surveying?

A. I was not surveying, no. I was just asked to try to locate exminers and try to x-ray them.

Q. After it closed?

A. After it closed.

Q. And you put notifications in the paper and on radio and...

A. Papers, television, radio and everything.

Q. And you have no idea how many people responded to that?

A. Oh, I got one letter even from California. They send me the x-ray film, was clear.

We get them sometimes that far away.

Q. What do you think is the purpose of medical surveillance?



A. That's a very good question, I think.

Without medical surveillance, I guess, we would  
5 never realize what's happening to different hazards or different  
chemicals. I think all tests are good, biological tests are good,  
animal tests is good, dust count is good, but you still are never  
exactly sure how it affects the human beings unless you are  
watching those human beings, watch them carefully, follow them  
regularly and then you can more or less assure either the  
10 product is toxic or is not toxic.

Q. One of the purposes in the recommendation for  
the asbestos standard is to...and it's true of all the other  
standards in Ontario...is to determine the fitness of workers  
to be exposed to asbestos - ensuring fitness for exposure to  
15 asbestos is the first purpose, objective of a medical surveillance  
program?

A. Well, it's not exactly...first, not really  
is the fitness. We try to see whether there is going to be  
occupational disease that develops, whether these people develop  
asbestosis. Where he is fit or not fit physically, that is not  
20 really our problem.

Q. No, I understand that you are not doing  
the pretesting...

A. We don't like to see the guy who has already  
emphysema or chronic bronchitis, all really lung problems. to  
get in asbestos and possibly get worse. But generally we can't  
25 do nothing if he insist he goes. He is privileged.

In silica we had a rule at that time that we  
could say no, you are not going. In asbestos there was no such  
a thing.

Q. As a physician with a lot of experience with  
30 asbestos exposure now, or people with asbestos exposure, how do  
you determine the fitness to work with asbestos?



Q. (cont'd.) I mean, I'm asking a medical opinion as opposed to...

A. Fitness lungwise? Fitness lungwise, or what mean fitness?

Q. I don't know. I'm asking you.

A. You are quoting me the new regulations.

Q. Yes.

A. That's why I am not with Ministry of Labour or Health.

DR. UFFEN: May I ask a question, since you raised this. Did you retire from the ministry, or did you resign?

THE WITNESS: Resign.

DR. UFFEN: Thank you.

MISS JOLLEY: Q. Can we ask you why you resigned?

THE WITNESS: A. Well, you pose nice question before. Because I felt occupational chest disease fitness would not pick up the physical fitness for maybe football team or anything, and I was concerned only with the lungs. I expected minimal standards for the lungs. I don't want a guy with emphysema, with asthma, with chronic bronchitis, enter dusty occupation - whether asbestos or silica or talc.

But those that know better, they put physical fitness. It mean you have the muscle such a size, the back such a size, or I don't know what. But that is irrelevant.

But I don't think that's not irrelevant here, too. (sic).

MISS JOLLEY: I have no further questions, thank you.

DR. DUPRE: May I ask, Mr. McCombie and Mr. Lederer, whether we perhaps can take a ten minute break or so, with the general idea that we might still be able to finish around five o'clock or shortly later?

MR. MCCOMBIE: Yeah, I just have several questions.





MR. McCOMBIE: (cont'd.) I don't expect to be too long.

MR. LEDERER: I think there's a very good chance that I won't have any questions.

DR. DUPRE: Well, then, why don't we break until four-twenty.

THE INQUIRY RECESSED

THE INQUIRY RESUMED

DR. DUPRE: Mr. McCombie?

CROSS-EXAMINATION BY MR. McCOMBIE

Q. Okay, I just have...I would like to focus on the advisory committee to begin with, if I might. I'll just switch around the order of the things that seem to have gone today.

I've got several, I guess basic questions, that I'm quite in the dark with as far as the advisory committee goes. Now, you indicated that you personally were on a contract, and I gather that's with the WCB?

A. Mmm-hmm.

Q. As of 1971?

A. 1971 or 1972.

Q. Would it be fair to say...and I realize you can't say this from direct experience...but just from talking to other people there, is that generally the case with the other members of the committee, do you know, would they all be on contract with the Compensation Board?

A. My feeling would be yes, but I'm not too sure.

Q. The chairman, again, you say was a Dr. Rorabeck?



A. Dr. Rorabeck.

Q. Who would have appointed Dr. Rorabeck chairman?  
Would that have been the committee...

A. No.

Q. ...or would that have been the Compensation Board?

A. Compensation Board.

Q. The committee as a whole, who would they ultimately be responsible to as a committee? Would they be responsible to the Compensation Board?

A. Yes, we...yes, strictly the Compensation Board.

Q. So you are, in effect, an arm of the Workmen's Compensation Board for the purposes which you carry out at Grosvenor Street? Would that be fair to say?

A. We carry the mandate given to us. Our mandate is simple - confirm diagnosis and assess impairment.

Q. This is a mandate directly from the Workmen's Compensation Board?

A. Workmen's Compensation Board.

Q. And there is no other outside input from the Ministry of Labour or the Ministry of Health?

A. No.

Q. Now, the offices at Grosvenor Street, from which the committee works from, are those offices in the name of the committee?

A. No. Just.....fortunately I have a large, big room and we could accommodate members there for the meetings.

Q. And when people are examined, they are examined at Grosvenor...

A. Oh, we have examining room for our office, for our occupational chest disease service, and this examining room we are using the same for compensation cases.



5 Q. So in other words, the Ministry of Labour would allow the Compensation Board's advisory committee to use this room for the purposes of examining compensation claims?

A. That's correct. Yes.

Q. Is there any staff of the advisory committee?

A. At present I know that soon is going to be.

Q. I see.

10 A. Secretary is going to be now...I think the negotiator has been hired by Compensation Board because Ministry of Labour really objected, so is going to be...advisory committee is going to have their own secretary for typing reports.

15 Q. So at this point, at this point, though, there is virtually no overhead as such for the advisory committee? You don't pay for office space, you don't pay for secretarial help? It's all sort of distributed through the various members. Is that fair?

A. That's correct.

20 Q. Now, it has been asked, I think, by both Mr. Laskin and Mr. Starkman, as far as what contact members of the advisory committee have with the Compensation Board, and you have indicated that there is virtually no contact as far as policy or criteria go?

A. Correct.

25 Q. And that when you started, using yourself as an example, your job description, as it were, was laid out to you by Dr. Stewart, plus training-on-the-job program, if you like, with other members of the committee?

A. That's correct.

30 Q. Was there ever, in your discussions with Dr. Stewart or in your sitting in during the first phases of your appointment, was there ever any discussion, any looking into the whole question of the legal or administrative aspects



Q. (cont'd.) of the Workmen's Compensation in Ontario?

A. No.

Q. So there has never, as far as you are aware, been any discussion within the ACOCD of what constitutes a compensable claim and what does not?

A. No, no.

Q. From either a legal or an administrative point of view?

A. Really, no. In beginning I used to see lung cancers, but later on because they became, I presume, automatically compensable, we don't see them anymore.

Q. You are saying lung cancers are all...

A. For asbestos workers.

Q. Lung cancer for asbestos workers is automatically compensable?

A. That's what I get the impression.

Well, they not referring to us anymore.

Q. Okay. You mentioned earlier some cases, and I think the number was four on the code, of a grey area where there is something that's showing up, but you can't actually determine whether or not it's asbestosis.

In those kind of cases, what would you report to the Compensation Board?

A. No, Workmen's Compensation would not report. Workmen's Compensation Board would receive the same report what the plant doctor, physician, receives. It's just a copy to the plant physician.

Q. But if a worker came to you at the ACOCD, and was examined and the examination revealed the equivalent of a code four, what kind of a report would go to the Compensation Board?

A. Oh, I see. Maybe would be just a slight effect





5 A. (cont'd.) of asbestos dust inhalation. Even could be slight asbestosis, no functional disability, and we recommend the claim should not be allowed.

Q. So you would recommend in that case that, if in your view there was no functional disability...

10 A. Disability, and there is very slight asbestosis, it may be not allowed. Maybe it would be ten or fifteen, twenty percent. Depends on the Board, the members of...

DR. DUPRE: Mr. McCombie, I just want to get something clear in my own mind.

As I understood your description of the South African-derived diagnostic code...

15 THE WITNESS: This is strictly for us.

DR. DUPRE: That was strictly for Ministry of Labour purposes?

THE WITNESS: Labour purposes.

DR. DUPRE: You did not use that on the ACOCD, is that correct?

20 THE WITNESS: No, no. We using the same, yeah.

DR. DUPRE: You do or you do not?

THE WITNESS: Use, we using, yes.

DR. DUPRE: Oh, the ACOCD uses one and the same South African-derived diagnostic code as does the Ministry of Labour in its testing?

25 THE WITNESS: That's right.

MR. MCCOMBIE: Q. Maybe just to follow that up and bring it full circle, do you know if the WCB would use the same code?

30 THE WITNESS: A. Well, I think...I don't know, WCB...I guess they put in computer something, but the WCB, we not have concern with the code. We give diagnosis, we telling in the words on the bottom what it is.



DR. DUPRE: The purpose of your code, as I understood it, was simply to give to a statistical clerk a means of quickly compiling ...

THE WITNESS: That's correct.

DR. DUPRE: ...the categories for an annual report?

THE WITNESS: That's correct.

DR. DUPRE: So if, when the ACODC is advising the WCB on compensation, why would it have any need for that South African-derived diagnostic code?

THE WITNESS: Really maybe not, but they have the computer, I think, prefer to put this on computer, I presume.

DR. DUPRE: Oh, on the computer you still use those numbers?

THE WITNESS: They still adding with the code.

MR. McCOMBIE: Q. I'm sorry. Which computer is this, now?

THE WITNESS: A. The Compensation Board. I presume they still....you should double check with them.

I think they use for their computer four or five, or something, yeah. But for us, is irrelevant. We telling in words, number one, no asbestosis or asbestos dust effects; number two, chronic bronchitis; third, heart disease; four, disability five percent.

Q. Well, I don't want to get back into the code. We seem to have run into a great deal of time with that earlier this afternoon, but...

A. Yeah, I try to say that this South African code is not fit at all to asbestosis.

Q. Well, why is it used then?

A. Because the reason is we didn't feel introducing, second, next thing, we did not have enough trained doctors to use ILO code. I think this is going to be introduced in the future.



5 Q. Okay. Just to leave aside for now, anyway, the whole question of the code, what I'm trying to get at is when you get the grey area, quote, unquote, case, and you send a recommendation to the Compensation Board on that particular case, maybe if I can tell you what my concern is, maybe you can answer it.

10 My concern is that you as a doctor and the rest of the people at the advisory committee as doctors are making a legal judgement on what is a...or making a medical judgement on what is a legal question. I'm wondering how you can do that without any administrative or legal training whatsoever, and how you can say to the Compensation Board this person should or should not receive compensation, if you are not aware of the rules and the guidelines and the law by which compensation is  
15 granted in this province?

A. We think the man do not deserve compensation at the amount of this impairment, not disability...

Q. Excuse me, excuse me.

A. ...we call impairment.

20 Q. Excuse me just for a minute, but with great respect it's not up to you to decide whether or not he gets compensation. It's up to the Compensation Board.

A. That's correct, yes.

Q. That is their mandated function, is to decide whether or not someone is going to get compensation.

25 A. Mmm-hmm.

30 Q. From what you have told us today, from the report that was commissioned for the Royal Commission by Professor Barth and his looking into the functions of the ACOD, it seems to me very clear, and also from my own experience, that basically whatever the ACOD says, the Board does. And I'm quite concerned that this is done in a fashion without any legal or





Q. (cont'd.) administrative practice on your part, and with no accountability to anyone.

5 A. Well, I am not aware if they are accepting our recommendations with regard to disability. We recommending only impairment, and I like to make this very clearly, because we recommend the man is either not impaired or impaired ten, fifteen, twenty percent. Does not mean disability. That is Compensation Board...they decide disability.

10 Q. Earlier on you used the terms interchangeably, but I guess I can appreciate those differences.

A. No, that's impairment. That strictly should be impairment.

15 Q. Impairment. Okay, well how about the question of, again, the question arises when it's a grey-area case, it concerns me that the Compensation Act itself calls for a presumption that where someone is exposed to...or where someone has one of the pneumoconioses...there is an automatic presumption that that arose out of the course of employment, and yet you are making a judgement whether or not that arose out  
20 of the course of employment, in those grey-area cases. You are saying that a person does have some asbestosis, but you don't think it's sufficient.

A. It's true, maybe he is not impaired. Because asbestosis by itself is not necessarily meaning impairment. Pneumoconiosis by itself does not just mean impairment.

25 Q. Can I just ask something related. Do you do similar...I gather that the advisory committee does similar readings for other kinds of diseases - silicosis, pneumoconiosis - is that...

A. Including crushed chest, chest injuries.

Q. Chest injuries.

30 A. A certain amount.



Q. So you would make recommendations to the Board on...?

A. Impairment.

Q. Impairment in other cases as well as asbestosis?

A. Yes, yes.

Q. And this would all be done on the basis of the guidelines that we discussed earlier with Mr. Laskin, presumably there's other guidelines for traumatic cases and for the different diseases?

A. Mmm-hmm.

Q. Where do these guidelines come from?

A. Well, I think guidelines is a book published. This booklet is published strictly for lung function point of view. I guess we have copies distributed here.

Q. This was exhibit fifty-four, I believe it was, that was distributed earlier?

A. Yes, I guess so.

Q. And that...would that cover traumatic injuries as well?

A. No, that would not cover. No, traumatic is different part, different paragraph.

Q. But you would deal with traumatic injuries, would you?

A. Very rarely, because they overlap into orthopedics, but if is orthopedically no problem, only like rib cage healed well and according to orthopedic surgeon the man should not have disability, but the man, regardless, has disability, they sometimes refer to us to find out maybe a trachea injury, maybe a bronchial injury. That would be our responsibility.

Q. I guess what I'm trying to get at is, and I'm



5 Q. (cont'd.) trying to fit this all into the  
context of the role of the advisory committee in the overall  
scheme of things, and as I understand it, the advisory committee  
is essentially an arm of the Compensation Board that makes  
recommendations, and yet at the same time I've been told in the  
past by members of the advisory committee and by the Workmen's  
Compensation Board, that it's an independent group. I'm  
10 wondering how you justify those two things. It doesn't seem to  
me very independent if it's funded by the Compensation Board,  
if the members are selected by the Compensation Board, and if  
they are making direct representations to the Compensation Board,  
or recommendations.

15 A. Yeah, and this is correct, saying who is  
the boss, who is paying the salary, because the salary is so  
minimal, just a gratuity, so I don't think this reflects much  
our dependence on Compensation Board.

20 Q. Well, would you see yourself as consultant  
to the...I mean,...let me put it another way, would you see  
yourself having a doctor/patient relationship, medically  
speaking, ethically speaking, with someone that came to see you  
at the advisory committee?

25 A. I try to detach myself as much as possible,  
because I act as a consultant and my report should go to the  
referring doctor, or Compensation Board, or the family doctor.  
That is not directly. The same like life insurance - a guy  
comes to you - life insurance doctor, is no doctor/patient  
relationship.

Q. So you don't feel there is a doctor/patient  
relationship?

30 A. Well, because I was...those people I x-rayed  
for so many years, and talked to them, some what you get attached,  
but professionally when I was examining for advisory committee  
I had to put certain level line, because is not my patient. I



A. (cont'd.) acting detached or strictly professional manner.

5 DR. DUPRE: Do you consider yourself a consultant to the Board physician?

THE WITNESS: Yes.

DR. DUPRE: To the Board's physician?

THE WITNESS: To the Board, yes.

10 DR. DUPRE: To the Board, or to the Board's physician?

THE WITNESS: To...well, I think...

DR. DUPRE: In terms of a medical relationship?

THE WITNESS: Well, I report to the Board physician, yes. Not to the Board, to the Board physician.

15 DR. DUPRE: So you consider it, in terms of medical relations, you consider yourself a consultant ...

THE WITNESS: To the Board physician, yes.

DR. DUPRE: Who is Dr. Stewart?

THE WITNESS: Dr. Stewart.

20 DR. DUPRE: Again, in terms of medical ethics, that relationship to Dr. Stewart, as a consultant to the Board physician, is basically similar to the kind of relationship you would have professionally as a consultant to a family physician if you were called in on a case?

THE WITNESS: Correct.

25 DR. DUPRE: They are one and the same?

THE WITNESS: Mmm-hmm. Because some people used to come directly to me, and ask advice regarding lungs, colds or so on. I felt always somewhat guilty talking directly. I always felt he should go to his family doctor.

30 MR. MCCOMBIE: Q. Okay. Just to follow this up a little bit. Let's take a hypothetical example of someone that comes to your committee and is examined and, as Mr. Starkman





Q. (cont'd.) read in a letter, and let's take that as a hypothetical case, where the recommendation was for no compensation, and let's assume that that worker appealed that... you know, that that decision was accepted by the Board, the Board turned the person down and an appeal was made by that particular worker.

Would you ever see that case again? Would the Board say, this worker has got further evidence from another specialist and we would like you to consider this, on appeal?

THE WITNESS: A. This very often happens.

Q. So you would be sitting in judgement on your previous...

A. Yes, yes. Even if we find other evidence. For instance, we found a biopsy report which showed unequivocally that the man has a certain disease.

Q. Well, let's assume that there wasn't any startling new medical information that was obtained between the time that you first examined the person and the time of the appeal, but let's assume that there were different interpretations or different diagnoses...not diagnoses, but different considerations by other specialists. Would it be likely that the Board might refer it back to you?

A. Yes, they do refer it, very frequently.

Q. So would the Board...so in other words, the Board refers you back to a decision that you've already made and asks you to sit in judgement on it again?

A. Yeah. For instance, like the Board gets another letter from the family doctor or a specialist, and then they request us to examine the man again and re-evaluate again. That's a common procedure.

Q. Do you know if they use any other outside consultants, other than the advisory committee?



A. I think they use, yes.

Q. You think so, but you are not...

A. But not sure.

Q. You are not sure.

Again, what I'm trying to get at is the question of an appeal process which the Compensation Board has. I find it somewhat disturbing that the people who make the original decision are again asked to sit on their own decision and from a quasi-judicial point of view that strikes me as a little bit odd that the original decision maker is asked to again look at an appeal on his own decision. There is no outside avenue that you are aware of?

A. Generally is additional information there... That's why appeal is...what was not available to us. Generally, maybe patient's condition deteriorated. Sometimes time just lapse. We'll say we examine in two years. The man suddenly develops complications, or something, and asks to see us.

Q. Well, given the fact, let's, again, with a hypothetical example, given the fact that there is no new medical information, that there is no deterioration, but that there is a different interpretation on the diagnosis from the patient's own doctor, the patient's own specialist, you are saying that the advisory committee is above making a mistake at that fundamental level. Is that what you are indicating?

A. I think we glad to review our case, in case we did make mistake, and we gladly accept review cases. We never refuse. If Compensation Board requests a review of the case, we very gladly review the case.

DR. DUPRE: May I ask again, when you review the case, do you review the case that is referred back to you by Dr. Stewart?

THE WITNESS: Yes.



DR. DUPRE: So that once again, I can take it, that you are indeed acting as a consultant to a physician?

THE WITNESS: Yes.

DR. DUPRE: Who is Dr. Stewart?

THE WITNESS: Yes.

DR. DUPRE: As in other instances quite outside the realm of government, a consultant will consult the family physician; the family physician from time to time may refer a question back to a consultant?

THE WITNESS: Yes, correct.

DR. DUPRE: So the consultant/doctor relationship then would capture the essence of your relationship with the WCB?

THE WITNESS: Correct.

DR. DUPRE: It is not really a legal relationship or an administrative relationship?

THE WITNESS: No.

DR. DUPRE: It is the relationship of a consulting physician to a family physician?

THE WITNESS: Correct.

MR. McCOMBIE: Q. Okay, maybe if we could move to the occupational chest disease section, I just have a few questions on that.

I think you indicated this to some extent in your answer to one of the earlier questions, but maybe if you could just elaborate on it. When your service would be going to the different factories or plants, and there would be, let's assume that there would be an increased number of x-rays showing up, would you in any way have any input into the policy, into the regulations and enforcements...you have indicated you would send memos to your particular supervisor...but would your branch in any way be involved with setting regulations and methods of enforcement, methods of monitoring, things of that nature?





THE WITNESS: A. Yes. Now, regulations are written far apart - once in ten, once in twenty years. Once they been written, they are very hard to modify. But if new regulations are drafted, yes, we are consulted.

Q. You would be consulted?

A. Yes.

Q. How about, let's say the number of visits from the enforcement branch, would you be consulted on that?

A. You mean if the company do not comply with the new regulations? That's the question?

Q. No, I was more concerned with you going in and realizing that there was a dramatic increase, let's say, in the number of asbestosis cases coming out of a particular place.

A. Mmm-hmmm.

Q. Surely you must have some feeling that there is a cause for this and perhaps the place should be monitored more strictly, or more closely, and I'm wondering what the lines of communication would be.

A. Well, generally, the first thing I do phone, and next thing I send a note to say at that particular plant I diagnosed, during 1976, five new cases of silicosis, or berylliosis, whatever disease is...I wish you would go in and investigate.

Very often you find some new disease, new changes which was not expected. I say, would you look for such and such a mineral, whether it is not used.

Q. Who would you ask that of?

A. There would be mines, there would be Ministry of Mines. Or if it would surface industries, that would be the industrial health and safety.

Q. So it would depend on...

A. On who is involved.



Q. But in the case of asbestos, other than...

5 A. Asbestosis, likely this would be most likely Rajhans, or...I would write to Mr. Rajhans, because he is at the same level and he is in the same branch, and would trigger him to say, well, go and look what's going on.

10 Q. Would any of the members of the mobile x-ray unit, would they have anything to say with respect to the perceived hygiene in a particular place? You know, I realize that they are not engineers and they are not hygienists, but if you are in a particular plant, you are noticing a problem there, I mean would they have any input into that?

15 A. I don't think they generally go in the plant. They just be parking outside the plant and our contact man runs to the personnel manager and he gets the people to the van. They generally have no influence.

And they not trained, they not aware what's going on.

20 Q. Would there also be any mechanism within the section to notify the Workmen's Compensation Board when a particular x-ray showed asbestosis?

A. Well, I always try to report to our own branch. I thought they are responsible.

Q. So are you aware if the branch would be responsible for...

25 A. The branch should go and investigate and see what is the cause.

30 Q. But if I'm working in plant X and I come to your mobile x-ray unit, and you x-ray me and there's indications that I've got asbestosis, there is no assurance that I have that you or someone in the ministry would automatically notify the Compensation Board that there is a potential industrial disease here?



A. Well, I think I would not be directly involved, because I don't know even to whom to mail this report.  
5 But Dr. Stewart...

Q. So there is no liaison with the Compensation Board?

A. Well, I think there is liaison at higher levels. But Dr. Stewart, he would get the report on your chest, that you have asbestosis.

10 Q. Dr. Stewart would get a report from you?

A. From me. Copy of report...family doctor or plant doctor, and he would get copy.

Q. I see. Then it would be up to Dr. Stewart and the Board to follow it up?

15 A. Well, there would be family doctor to file the claim, and Dr. Stewart...sometimes I do recommend claim in the letter to the family doctor. I say, if this man looks an occupational disease, if he has symptoms or disability sumptoms, I would recommend to file the claim. That is very often in my letter. I report this to the family doctor.

20 Q. Now, did the occupational chest disease section, other than the mobile x-ray units which were operated, were there any other studies that were undertaken by that section?

A. Yes. Now, I think...well, we just did the firemen study in Cooksville, or Oaksville. What was it? Cooksville. And we are studying Barrie fire, what happened there, and  
25 sometimes...we did Elliott Lake Mines study, rather extensive, when there was sudden burst of silicosis in Elliott Lake Mines.  
We do some studies, yes.

Q. One thing I would like to ask, which I am not sure you would be in a position to answer or not, and it  
30 is just something that has come up in my mind, and I don't know whether anyone during the hearings as addressed this, but do you



5 Q. (cont'd.) know if anyone has done any studies on the psychological impact of asbestos, insofar as a worker all of a sudden discovering that they do have an asbestos-related disease, and given the fairly high profile of asbestos as a toxic substance, the effect that that may or may not have on individuals?

A. You notice this very much by examining those people. Yes.

10 Q. You notice it, but do you know if there are any studies that are done by the ministry or anyone else?

A. I don't think there was psychological studies done, but that was a fact I felt very strongly about - many people been disturbed, and disturbed to depression and anxiety and so on.

15 Q. So you would see this in both your role with the chest disease section and the ACOCD?

A. Yes. But we don't have a psychologist or nobody in this kind of field.

20 Q. If you saw someone at the ACOCD that was obviously suffering from a depression due to this, would you report that to the Compensation Board?

A. Yes, I do.

Q. Would you make any recommendation as far as compensating them?

25 A. Not recommend compensating, but I sometimes recommendation to psychiatric consultation or psychological assessment, and so on.

Q. But you wouldn't put a number on that the same way as you would on the impairment, clinical impairment?

30 A. No, at present time we do not compensate for this disturbance, no. Because we don't have psychiatrists on our staff, and this would be just...





Q. You don't compensate? Well, you don't compensate for asbestos...

A. For psychological.

Q. Oh, you don't compensate for asbestosis either.

A. No, no. We would not know how much impairment the psychological disturbance was effecting. If you had psychologist...but we recommend psychological consultation, to Compensation Board, or psychiatry or something. If I think it's obvious the man is disturbed...

Q. But you wouldn't say to Dr. Stewart, there's also a psychological impairment and we suggest that your...

A. Yes, we occasionally recommend that maybe it would be good idea to consult or refer to psychologist or psychiatrist for opinion.

DR. DUPRE: If I understand your answer correctly, you would recommend that this individual be referred to a psychologist?

THE WITNESS: Yes. Mmm-hmm.

DR. DUPRE: You would not make an assessment of psychological impairment?

THE WITNESS: No, no.

MR. McCOMBIE: Q. Along somewhat similar lines you answered earlier to Mr. Laskin, I believe, about a situation where there is a pre-existing disability such as chronic obstructive lung disease, or emphysema, or something like that, that's compounding the effect of the asbestosis. You indicated that only in extreme example where it was patently clear that there was a pre-existing condition would you differentiate between the total overall assessment?

THE WITNESS: A. Yes.

Q. Are there any particular guidelines that you would use as to what is a very clear, pre-existing condition and



Q. (cont'd.) what is sort of murky?

5 A. No. If you can' diagnose obvious allergies,  
if you can diagnose obvious emphysematous changes, emphysematous  
bulla, in the lung function test you can see how big is the  
residual volume, three times, maybe, normal, this is diagnostic  
that this man has obvious pulmonary emphysema, or if doing  
lung function test after bronchodilators is very good improvement  
of his lung function, you know that it is allergic phenomenon,  
10 well, this is diagnostic and we know that it is not due to,  
definitely not due to asbestos.

So this would be, naturally, considered in his  
disability assessment.

15 But if there is only slight evidence, because  
well, he's restricted, he's a little obstructed, his residual  
volume is a little increased, those things we not considering.

Q. How about if there is moderate evidence?  
What I'm trying to get at is, where do you draw the line?

20 A. Where is the line, yes. Well, this is always...  
there is the firm doctors who decided the line, but they have to  
be clearly diagnosed. My diagnosis should be there - pulmonary  
emphysema. If I put on diagnosis pulmonary emphysema, this  
means without any doubt there is emphysema.

Very often in recommendation we will say,  
disability rating twenty percent for asbestosis.

25 Q. Okay. Well, leaving aside the two extremes,  
again what I'm trying to get at...

A. The borderline.

30 Q. ..is the borderline cases, and are you saying  
that there is no written criteria either from the Workmen's  
Compensation Board or that have been developed by the advisory  
committee themselves?

A. Well, here goes the clinical judgement, what  
we call.



Q. So that would be a judgement call?

A. Yeah, clinical judgement.

5 Q. There's no written guidelines or criteria that are used?

A. Well, I think in those they have to do clinical judgement, and that's why the five doctors is there, and decide that clinical judgement should be as separate as possible.

10 Q. Do you know when this was decided? I mean, there must have been at some point some communication with Dr. Stewart, or the rest of the Workmen's Compensation Board, to let you know that if there was a mild case aggravating the asbestosis, say a mild case of obstructive lung disease, aggravating the asbestosis, that you should ignore that in your overall assessment. So there must have been some communication,  
15 because they are giving you legal guidelines on these things and I'm wondering where it's written down. I mean, everything seems very, very vague.

A. Is nothing like...well, we not telling Dr. Stewart those things. We think the man has asbestosis, period.

20 Q. So you just wouldn't bother to include that in your diagnosis?

A. No.

Q. All right.

25 Okay, I just have one other question. Are you familiar with a program that surveyed family members? I mean, when you see an asbestos worker, you are obviously dealing with someone that has obvious...

A. This means study around the neighborhood, in Johns-Manville, family member study? That's what you referring to?

Q. Yeah.

30 A. Yes. I did the study.

Q. Where is that study? What's going on with it?





5 A. I think this medical officer of health for Scarborough, he initiate it and we complete it. How many, whether...

Q. I'm just wondering if it's available.

A. Dr. Fitzgerald, he promised to publish this study.

Q. Dr. Fitzgerald?

10 A. Yes. But for some reason I didn't see the publication.

Because we x-rayed the wives, and children and neighbors and so on, and we did lung function study of them, and we...well, we did technical part, so he was...

Q. This is the chest disease section we are talking about?

15 A. Chest disease section, yeah, and Dr. Fitzgerald, medical officer of health for Scarborough, he initiated this program, and we are still waiting for publication.

MR. McCOMBIE: Okay. I think that's all the questions I have. We seem to have lost our quorum of commissioners anyway, so...

MR. STARKMAN: I'm just wondering, with respect to that study is there any chance that we could follow up and see if it...

MR. LASKIN: I intend to.

25 DR. DUPRE: I think our counsel can hardly contain himself with a couple of followup questions.

Mr. Laskin?

EXAMINATION BY MR. LASKIN

Q. Can I just understand...you said you did the study?

30 A. We did read the films and we did lung function tests.



Q. When?

A. When the study was done.

5 Q. Well, I mean did you read the films and do the lung function tests...

A. Yes.

Q. ...in the last couple of years?

A. No, no, no. Tests would be about seven years, five, seven years ago.

10 MISS JOLLEY: In 1974 or 1975.

THE WITNESS: 1974 or 1975.

MR. LASKIN: Q. Who did you actually examine? Did you try then-present employees' families?

THE WITNESS: A. Yes. Present employees' families...present and past employees' families.

15 Q. And past?

A. And close contact. Anyone who lived...like brothers and sisters and aunts and grandmothers, and so on.

Q. What kind of trace rate did you get? How complete was your population?

20 A. I think was very good study, I think. It was very good compliance, I can remember, and we been really shocked because I saw two cancers of asbestos...pleural plaques, not asbestosis, pleural plaques, and then only later on came out that they been exemployees.

Q. Did you see any malignancies?

25 A. Not in this group. Not at this time, no.

Q. Who did you do it for? Did you do it for the ministry or for the Scarborough...

A. No, Fitzgerald. For Scarborough Health.

Q. At his request?

A. At his request.

30 Q. Did you keep a copy of your compilation, of your report?



A. Must be somewhere in the files, yes.

Q. In the ministry files?

A. Ministry files.

Q. Perhaps we can pursue that with the ministry, but I take it other than that you gave your results to Dr. Fitzgerald?

A. Yes.

Q. And...

A. We always keep copies ourselves, but must be in our files some copies.

Q. And Dr. Fitzgerald was then the medical officer of health for Scarborough?

A. Assistant medical officer of health for Scarborough, and he initiated and he was director of the study, and he hired statisticians, analyzers, anything. We did just the technical work.

Q. You did the testing. I take it that's something we should follow up with Dr. Fitzgerald.

A. Yeah, I think you should.

Q. All right. I have a few other questions I wanted to follow up.

A. Sure.

Q. One arises from the questions Linda Jolley asked you, and I don't want to embarrass you, but at the same time I just want to understand, or I think the Commission would like to understand, your resignation, because if I heard your evidence correctly it was in effect on a point of some principle you...am I putting that accurately?

A. I want to go into private practice, want to make more money. Okay, leave it this way, and I was maybe a little unsatisfied with present rules, regulations. It was minor. No, that's not essential.



Q. All right, but did you have some dissatisfaction with some part of the new proposed asbestos regulations?

5 A. Not only asbestos, but general regulations, yes. I had disagreement, but everyone has disagreement. If I was overruled, that means that maybe others are right.

Q. Dr. Vingilis, nobody is criticizing you for being overruled or whatever. This Commission...you are a person of some experience in the field and if you have a particular  
10 view as to the appropriateness or otherwise of a particular regulation, I think the Commission would like to hear about it.

So if there is some...can you be more specific as to what the basis of your disagreement was? With the regulation. I'm not interested in whatever private quarrels you may have had with the ministry.

15 A. No, no. I didn't expect this question and I think I should think over a little and be more precise. If you leave me at this time, because I never expected this question, I say.

MR. LEDERER: Mr. Chairman, I wonder if I might  
20 make a brief comment? I'm not just clear on how this affects Dr. Vingilis, and I'm not even sure that I'm directly objecting to the question. Certainly Mr. Laskin has taken great care to word it very mildly, but it does point up a problem that come up often when government employees are called to give evidence before commissions such as this.

25 As I say, I'm not frankly even clear in my own mind at this moment whether it really does come up for this question, but I may raise it because I think it's going to come up later, if not with this question. I think the Commission will want to consider it carefully.

30 It seems to me that in relation to the public service it is one thing to have a public service servant come





MR. LEDERER: (cont'd.) before a commission of this type and indicate what government policy is, and indicate the framework in which the government has chosen to operate in any particular area - in this case the area of occupational disease.

It may be quite another to ask that public servant his personal opinion. He is really not here because he has a personal opinion. He is here because he was, in this particular case, and for the most part, most of the people you will be hearing are, public servants. It seems to me that questions of this type can frankly be embarrassing, certainly to somebody who is continuing to work within the public service, who is really being asked, in effect, to disagree with his superiors.

Now, it may or may not be that such a question is irrelevant. The question really is whether or not there is sufficient weight in any such question that it assists this Commission in hearing that evidence, to the point where the person should be put in that position.

I think you are hearing, in Dr. Vingilis' answer, just that kind of difficulty, and I'm not clear...with all due respect to Mr. Laskin...whether the question really is of such importance to this Commission that Dr. Vingilis need be put in this position. I do not think that it really addresses the situation terribly far. The regulation is there, it's clearly open to criticism, it was not my understanding of the answer that Dr. Vingilis has given to this point that he disagreed with it on any principle that directly affects what this Commission is really looking at.

DR. DUPRE: Counsel, I take your general point as well put. A public servant who, while he remains in the public service and who then is asked his personal opinion on a



DR. DUPRE: (cont'd.) government policy, can  
as a result raise some rather interesting legal questions,  
concerning which there is voluminous material, both federally  
and I daresay provincially.

On the other hand, what I am interested in is  
simply focussing upon a very specific point that arose during  
Miss Jolley's questioning, which as it came across to me sitting  
here, had to do with the question of whether our witness...who  
of course I note is no longer in public service...had a specific  
reservation about a particular part of the regulation as it now  
exists in draft form...that particular part of the regulation,  
as I understood, having to do with one of the purposes of  
surveillance, that purpose as I understood it being the question  
of an individual's physical fitness to work with a substance.

Now, I think I don't have any hesitation, even  
in the absence of either of my colleagues, in saying outright  
that to the extent that proposed regulatory language that uses  
a term for the purpose of surveillance like 'physical fitness  
of an individual to work with a substance', if there is such  
proposed language and if there exists an honest professional  
difference as to whether this is appropriate in regulation, I  
would say that it is very much in the interests of this  
Commission to know what is behind this kind of reservation.

So, counsel, perhaps I'm addressing Mr. Laskin  
now, if you would wish to ask Dr. Vingilis about his specific  
opinion concerning the extent to which it is sound public  
policy, or whether it is worthwhile in a medical sense, to  
pursue medical surveillance from the standpoint of trying to  
insure an individual's physical fitness to work with a hazardous  
substance, I would be very interested in whatever our witness  
can help us with.

MR. LASKIN: Q. Can you help us on that? Was



Q. (cont'd.) that the point of...that we were talking about earlier?

5 A. I have to first think over and prepare and formulate any reasonable statement, I think, before I could give anything constructive, and I would be appreciative if you could excuse me from this questioning.

10 Q. Well, I may be prepared to do that, but can you just...can you help me...was your concern with what is called the code for medical surveillance of asbestos-exposed workers? Was that what you were referring to?

Will I help if I show it to you?

A. Yes.

15 Q. I am showing you what is the draft proposed regulation as of September 22, 1981.

A. It been changed so many times.

Q. That's true, but section thirteen of that regulation talks about pre-employment and pre-placement medical examinations under an asbestos-control program?

A. Mmm-hmm.

20 Q. Then subsection three requires that that meet the provisions of the code for medical surveillance, which is found at the back?

25 A. Well, I think, you know, this is still so very personal, and every doctor can have and use his own discretion to screen employees, and maybe discriminate employees, I don't know.

I not never really studied, I never really thought deeply on this thing, and I still afraid to say too much and I would thank my counsellor for trying to...for nice opinion.

30 I should think a little more and get more precise, and I don't have any one specific point.

Q. Well, can we have your undertaking, Dr. Vingilis,





Q. (cont'd.) to review that question and to provide to us...

5 A. I can go home and think over, and see what is...

Q. All right. Will you undertake to provide to us in writing your views on this particular issue?

Will you give us that undertaking?

A. Okay, I guess I could.

10 MR. LEDERER: I'm not sure if Dr. Vingilis understands what he has been asked, but if I can...

MR. LASKIN: I would be happy to have you explain it to him.

15 MR. LEDERER: What Mr. Laskin is asking for, Dr. Vingilis, is whether or not you are prepared to prepare for this Commission a written answer to the question that Mr. Laskin has just put you to...sorry, has just put to you.

THE WITNESS: You mean the points on which I would...do not disagree with the new regulations?

MR. LASKIN: Yes.

20 DR. DUPRE: This is, I think, with respect to medical surveillance.

MR. LASKIN: Medical surveillance, the point that Miss Jolley questioned you on earlier this afternoon and that started us on this line of questioning - particularly with respect to medical surveillance.

25 THE WITNESS: A. Would you repeat in a specific question? Because we have talked all afternoon. I...

30 MR. LEDERER: Mr. Chairman, maybe I can assist in this way...I don't know whether this will assist or not, but perhaps I can say to Dr. Vingilis that what Mr. Laskin is asking, it seems to me, particularly given your ruling, Mr. Chairman, is entirely appropriate and I think it's the kind of thing that Dr. Vingilis should be looking to do.



5 MR. LEDERER: (cont'd.) My only reservation is that it's frankly a little bit unclear to me as to just what precisely the question is. It seems at certain times to be broader and certain times to be a little bit narrower, and I'm wondering whether either the question can be asked precisely now as a matter of record, or whether it could be provided to Dr. Vingilis in some form so that he can, if he agrees with what I've just said to him, can prepare that written answer.

10 I don't know whether he will agree.

MR. STARKMAN: I would just like to interject before we get too far down the road. I have the discomfoting feeling that twice now we have had witnesses who have come and asked not to answer questions, and as we all recall the first time was with Dr. Kotin when he was here, and we dealt with that matter.

15 Now, Dr. Vingilis is asked a question, there was some discussion of it, and at least in the form it was asked, I understood the question and I assume that you, Mr. Chairman, understood the question, and that's why you ruled that he should provide the answer.

20 Now, it seems that the road we are drifting down is that when a witness appears at the Commission, is asked a question - whether it be uncomfortable, disquieting for whatever reason, feel that they don't want to answer it, then we immediately channel it into a way that will allow that witness to not answer the question.

25 Now, that may be the appropriate response in certain circumstances, but I think that without having addressing ourselves to whether or not that is the way we are going to proceed, we have to deal with each individual case, but it didn't seem we dealt with it in this particular case whether or not it is appropriate to allow Dr. Vingilis to provide a written

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MR. STARKMAN: (cont'd.) answer to a question which has been ruled appropriate, and which it seems he is able to answer in whatever way he is able to answer it.

It may be a better answer, a more complete answer, etc., if he is allowed the opportunity to provide it in writing, but we went through the whole exercise of whether or not the questions ought to be provided in writing beforehand when Dr. Kotin wanted that to be done. We decided that was inappropriate.

I'm just concerned that without addressing ourselves to the procedure, we are going to drift into a certain pattern from which we may not be able to reverse, down the road, should this problem become recurring.

DR. DUPRE: Thank you, counsel. I just want to make the following point as clear as I can.

If we are going to travel down any roads around here, we are going to drive them, we are not going to drift. That is point one.

Your reference to the original case of Dr. Kotin, with respect, I consider very different to this one, is at least case in point that we are avoiding drifting on land.

Now, as to the questions that Mr. Laskin has been putting to Dr. Vingilis, and the points that have been raised, let me, if I may, simply put the following to you here: I take it that I can consider you, in this instance of course, as counsel for the Government of Ontario. You have been here, Mr. Lederer, throughout our discussion today. Dr. Vingilis has, as I understand it, asked for some time so that he may try to come to grips with the nature of the question, which I thought was relatively straightforward as it was put by first of all Miss Jolley this afternoon, then Mr. Laskin, and perhaps rephrased by myself.

May I simply put this to you, Dr. Vingilis, if you would consider the following: That you would, if you please,





5 DR. DUPRE: (cont'd.) review the transcript of today's testimony when it becomes available, and if you might supply a written statement with respect to the opinion that you hold of that particular section of the proposed regulations. The section, as I understand it, is not peculiar indeed to the asbestos proposed regulation. It also deals with other substances.

10 But if you would be so kind as to provide us with a written statement which, from your expert point of view, would give us such enlightenment as you would like to give us on the purpose of medical surveillance in relationship to the regulation of hazardous substances.

15 And if you...it would turn out that you would prefer to come here and simply make a formal statement about it, I'm sure that counsel will be able to accommodate you on that.

If you do make a written statement on it, of course, and there are parties here who would like to question you about that written statement, well then of course we will try to arrange a time slot some time when those questions can be posed to you.

20 Would this be agreeable?

MR. LASKIN: That's fine.

DR. DUPRE: Any other matters?

MR. LASKIN: I have just one or two other questions.

25 MR. LASKIN: Q. I just want to come back to your role on the advisory committee again, for a moment, and perhaps a question that arises out of something that Mr. Starkman asked you.

We have heard from the WCB that in assessing claims the benefit of reasonable doubt, as the Board expresses it, is said to apply in favor of the worker.

30 Can I ask you whether that principle, first of all, has ever been communicated to the advisory committee?





THE WITNESS: A. Yes, I think we would be the same...any reasonable benefit of doubt goes to the worker.

5 Q. And the advisory committee, you say, understands that?

A. They understand, yes.

10 Q. All right. I have a couple of problems. I suppose my first problem is this, that you gave some evidence this morning when I questioned you about what the advisory committee did in cases of disagreement, and as I understood your evidence, in cases of disagreement, number one, the majority vote governed, and number two, when you reported to the Board... notwithstanding that there was some disagreement amongst you... only the majority view was communicated to the Board in its formal report.

15 In other words, you did not record the fact that one or more members of the committee might have disagreed?

20 Well, I suppose my question to you is, would not the advisory committee think in applying the principle of reasonable doubt, the benefit of reasonable doubt to the worker, either that if one or more of its professional colleagues, for example, has the view that a worker should be compensated, or is prepared to recommend that, whereas the majority don't, that either it should give effect to that or at least communicate that opinion to the Board so that the Board can apply its own principle?

25 A. It can be introduced.

Q. But it's not?

30 A. At present time, no. Because if one objects and four...it's a little hard, there is less...very little benefit of doubt if it's from five that only one is doubt and four is no doubt.

Q. I take it still professional men of some



Q. (cont'd.) experience?

5 A. So I think this is...opinion of the four, I think, outweighs the opinion of one.

Q. Let me put the second case. David Starkman read to you a form comment from one of your reports, and as I noted it at one stage it said 'no significant asbestosis', and you said that should more properly read no significant evidence of asbestosis?

10 A. That's correct, yes.

Q. All right.

But again I'm having trouble understanding, and you said what followed from that is no compensation, or no recommendation for compensation?

15 A. Correct.

Q. My difficulty is understanding that observation or conclusion against this principle of the benefit of the reasonable doubt applying in favor of the worker. It seems to me that if the committee is saying no significant evidence of asbestosis, that means impliedly there is some evidence of asbestosis?

20 A. Mmm-hmm.

Q. If that's the case, why isn't the committee, then, recommending on some principle of reasonable doubt that there should be some compensation?

25 A. There is...if his disability is compensable, not the disease. If there would be disability. You are mixing two things.

First there has to be diagnosis. Now, there is questionable whether there is asbestosis.

30 Next thing, there is no doubt, there is no disability. So when we compensate...there is no impairment. There is no impairment, which means no compensation, and next



A. (cont'd.) question, there is very questionable evidence if there is asbestosis at all.

5 If you put this together, how you can you can compensate?

There is very question whether there is asbestosis at all. There is no question there is no impairment. Now, how much you compensate?

10 Q. Well, that's really a judgement for the Board, and not for the advisory committee.

A. No, that's mean to recommend impairment. If there is no impairment. Even there is very little evidence whether there is disease.

Q. Okay. Well...

15 A. Now disability is compensable...I'm sorry... impairment is compensable, not the fact that there is a little disease.

Q. All right.

20 Let me just ask you, I just have one other question and it's totally unrelated to that...you spoke this morning about, or you were talking about...the chairman, I think, asked you what communications you may have had with corporate medical officers in companies such as Johns-Manville in the United States, and you mentioned your meeting with Dr. Smith.

A. Yes.

25 Q. All right. Did you ever have any such similar meetings with any corporate medical officers from companies other than Johns-Manville, in the asbestos field? I'm thinking, for example, of Raybestos Manhattan or Bendix. Did you ever have any of those kinds of meetings with corporate medical executives from across the border?

30 A. I always used to meet them at our medical conventions, occupational disease, whether is San Francisco or





5 A. (contd.) Boston or New York. I knew them personally, but they never visited with us in Toronto...although Raybestos Manhattan, I forgot his name, the doctor's name, he visited Toronto, but he didn't visit with us.

Q. He didn't visit?

A. No.

MR. LASKIN: Thank you, Mr. Chairman.

10 DR. DUPRE: Dr. Vingilis, may I thank you very much indeed...

THE WITNESS: Still, I didn't get exactly that question. What I should really say, pass my comment about the new, the proposed regulations on asbestosis?

15 DR. DUPRE: With particular regard to the section of that regulation that involves the purpose of medical surveillance...

THE WITNESS: Surveillance.

DR. DUPRE: ...under the program.

20 THE WITNESS: Okay. I have to read and refresh my memory.

DR. DUPRE: And I think that I can take it that we will see to it that a transcript is made available to Dr. Vingilis just as soon as it becomes available, and that the good offices of Mr. Lederer are certainly available to you if you need any points in there explained.

25 THE WITNESS: Okay.

MR. LASKIN: Thank you very much, Dr. Vingilis.

DR. DUPRE: Thank you so much, indeed.

THE WITNESS: You are welcome.

30 DR. DUPRE: I understand we now rise until the 14th of June.

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THE INQUIRY ADJOURNED

THE FOREGOING WAS PREPARED  
FROM THE TAPED RECORDINGS OF  
THE INQUIRY PROCEEDINGS

EDWINA MACHT







